2.0

CONTRACEPTIVE METHODS

Method Specific Consent Forms
Counseling Handouts
2.0 CONTRACEPTIVE METHODS

SERVICE POPULATION: Women and men of reproductive age requesting contraceptive services at Title X FP Clinics according to their Reproductive Life Plan (RLP).

METHODOLOGY

HOW TO USE THE U.S. MEDICAL ELIGIBILITY CRITERIA (MEC) FOR CONTRACEPTIVE USE, 2017
http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm (Appendix G)

The U.S. MEC uses four categories to classify medical conditions affecting a client’s eligibility for the use of each hormonal contraceptive method/device.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>No restriction (method can be used)</td>
</tr>
<tr>
<td>Category 2</td>
<td>Advantages generally outweigh theoretical or proven risks</td>
</tr>
<tr>
<td>Category 3</td>
<td>Theoretical or proven risks usually outweigh the advantages</td>
</tr>
<tr>
<td>Category 4</td>
<td>Unacceptable health risk (method not to be used)</td>
</tr>
</tbody>
</table>

Screening for Presence of Conditions
Conditions listed in the U.S. MEC represent either a person’s characteristics (e.g., age, parity) or a known pre-existing medical or pathological condition (e.g., diabetes, hypertension).

The table below shows an example of how the categories may be put into practice for a woman who smokes and desires combined hormonal contraceptives (COC).

<table>
<thead>
<tr>
<th>Smoking</th>
<th>COC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Age &lt; 35</td>
<td>2</td>
</tr>
<tr>
<td>b) Age ≥ 35</td>
<td></td>
</tr>
<tr>
<td>(i) &lt;15 cigarettes/day</td>
<td>3</td>
</tr>
<tr>
<td>(ii) ≥15 cigarettes/day</td>
<td>4</td>
</tr>
</tbody>
</table>

Contraceptive Method Initiation (I) and Continuation (C)
Recommendations include MEC for initiating and continuing use of contraceptive methods. If initiation and continuation recommendations differ, these are noted in the columns 'I' and 'C'; otherwise, the category is the same for initiation and continuation of use. Continuation criteria are clinically relevant whenever a client develops a health condition while using a contraceptive method.

Clarification of the Recommendations, Comments, and Citation of Scientific Evidence
In some cases, the numeric classification did not capture the complete recommendation, so additional narrative clarification was needed. Recommendations with a clarification are noted by an asterisk. The clarifications can be found in Appendix G Part 2.

MEC and Contraceptive Choice
Medical eligibility is one element a woman, man or couple may consider when choosing a contraceptive method. Other important elements include effectiveness, availability (including accessibility and affordability), and acceptability. For example, the classification of “Category 1” from the US MEC means that the method can be used in that circumstance with no restrictions with regard to safety, but it does not indicate the method is the best choice for that person.; Consider effectiveness, availability, acceptability, and STI risk in helping your client choose the best method. Voluntary, informed choice of contraceptive methods is an essential guiding principle, and contraceptive counseling, where applicable, may be an important contributor to the successful use of contraceptive methods (Contraceptive Technology 20th Revised Edition).
SUMMARY OF STEPS NEEDED TO SAFELY DISPENSE CONTRACEPTIVES TO CLIENTS

1. Take a detailed medical history; provide shared decision-making counseling, as described in Section 1.2.H.a Contraceptive Services; and use the U.S. MEC to provide clinical guidance on the client’s medical eligibility to use contraceptive methods. The “Quick Reference for Each Contraceptive Method” table below, can also be used in counseling.

**Contraindications** for contraceptives - do not provide if the client has:
- Known or suspected pregnancy; or
- **U.S. MEC Category 4** condition(s); or
- Severe allergy to a component in the method.

**Precautions** for contraceptives
- If client has condition(s) classified as **U.S. MEC Category 3**, If client has ≥ 2 conditions classified as U.S. MEC Category 2. This may put the client under MEC Condition “Multiple risk factors for atherosclerotic cardiovascular disease”, which as a result may place the client under MEC 3/4 for the method.

For either one of these precautions the clinician will document counseling of risks/benefits and reasons that the benefits outweigh the risk in the client medical record as well as the client’s understanding and acceptance of the risk.

2. How to be reasonably certain that a woman is not Pregnant - Take a detailed history and use the criteria listed in the box below.

History should include the following:
- Pregnancy symptoms (see below)
- Menstrual history: LMP and previous menstrual period (PMP) establish the date of last normal menses
- Sexual history: last (and any other episodes of) unprotected sexual intercourse since the last normal menses
- Contraceptive use past and current (including adverse effects and adherence)
- OB history including breast feeding.

Using the following criteria to rule out pregnancy is highly accurate (negative predictive value 99%–100%). If a woman has no symptoms/signs of pregnancy and meets one of the criteria, the health-care provider can be reasonably certain that she is not pregnant. Based on clinical judgment, a urine pregnancy test might be performed by a PHN/clinician bearing in mind the limitations of accuracy of pregnancy testing. If a woman does not meet any of these criteria, the health-care provider cannot be reasonably certain that she is not pregnant, even with a negative pregnancy test. (U.S. SPR)

**How To Be Reasonably Certain that a Woman Is Not Pregnant**

A health-care provider can be reasonably certain that a woman is not pregnant if she has **no symptoms or signs of pregnancy, and meets any one of the following criteria**:
- is ≤ 7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤ 7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breast-feeding, (exclusively breastfeeding or the vast majority [≥ 85%] of feeds are breastfeeds), * amenorrheic, and less than 6 months postpartum


**Symptoms of pregnancy**
- absent or altered menses
- nausea (with or without vomiting)
- fatigue (persistent)
- breast tenderness and enlargement
- increased frequency of urination
3. In managing a client’s specific contraceptive concern that is not described in the protocol, a clinician will use companion manuals: Contraceptive Technology (CT), Managing Contraception for your pocket, Managing Contraceptive Pill Clients (Dickey), and U.S. Selected Practice Recommendations (SPR) for Contraceptive Use, 2016.

**Quick Reference for Each Contraceptive Method**

**EFFECTIVENESS OF FAMILY PLANNING METHODS**

*The percentages indicate the number of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.*

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
<th>After Procedure</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant</td>
<td>0.05%</td>
<td>Get repeat injections on time.</td>
<td>Keep in place, change on time.</td>
</tr>
<tr>
<td>Intrauterine Device (IUD)</td>
<td>0.2%</td>
<td>Take a pill each day.</td>
<td>Use correctly every time you have sex.</td>
</tr>
<tr>
<td>LNG</td>
<td>0.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copper T</td>
<td>0.15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pill</td>
<td>9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patch</td>
<td>9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ring</td>
<td>9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (vasectomy)</td>
<td>0.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (Abdominal, Laparoscopic, and Hysteroscopic)</td>
<td>0.5%</td>
<td>Use another method for first 3 months (Hysteroscopy, Vasectomy).</td>
<td></td>
</tr>
</tbody>
</table>

**Contraceptive Use**

- **Male Condom**: 18% (18 pregnant per 100 women in a year)
- **Female Condom**: 21% (21 pregnant per 100 women in a year)
- **Withdrawal**: 22% (22 pregnant per 100 women in a year)
- **Sponge**: 12% (12 pregnant per 100 women in a year)

**Condoms** should always be used to reduce the risk of sexually transmitted infections. 

**Fertility Awareness-Based Methods**

- **Abstain or use condoms on fertile days**: 24% (24 pregnant per 100 women in a year)
- **Spermicide**: 28% (28 pregnant per 100 women in a year)

**Other Methods of Contraception**

- **Intrauterine Device (IUD)**: Remove and replace every 2-3 years.
- **Implant**: 5-7 years.
- **Intrauterine Device (IUD)**: 2-3 years.
- **Contraceptive Pill**: 6-12 months.
- **Contraceptive Ring**: 1-3 months.
- **Contraceptive Sponge**: 1-7 days.
- **Contraceptive Diaphragm**: 1-2 weeks.
- **Contraceptive Vaginal Ring**: 1-3 months.
- **Contraceptive Condom**: 1-4 weeks.
- **Contraceptive Sterilization**: Lifetime.

**Emergency Contraception**

- **Emergency Contraceptive Pill**: 1-3 hours after intercourse.
- **Emergency Contraceptive Injection**: 4-5 hours after intercourse.

**Signs of Pregnancy**

Physical exam will not help rule out pregnancy < 6 weeks but may rule out pregnancy > 6 weeks, and fetal heartbeat can be heard around 18-20 weeks’ gestational age by fetoscope (fetal stethoscope).

**Urine hCG Test**

When pregnancy is difficult to rule out or the woman’s history is unreliable, urine hCG might be helpful. It can be positive by 14 days after fertilization, and may remain positive until 3 weeks after an abortion. In later pregnancy (e.g., >10 weeks of gestation), the urine hCG can give a false negative result. The client may also be referred for serum hCG test at their own expense.
Contraceptive Methods

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2.1 CONTRACEPTIVE IMPLANT

A. EQUIPMENT

- Client counseling handout
- Implant Consent Form
- Sample implant device (preferably the rod palpation simulation model)
- Supplies
  - Sterile fenestrated surgical drape
  - Sterile talc-free gloves
  - Betadine swabs
  - Sterile 4x4 gauze sponges
  - 1% Lidocaine with/without epinephrine
  - Syringe 5 cc and needles (18g 1-1 ½", and 22g 1½”)
  - Pressure bandage Co-flex dressing
  - Sterile scalpel #11
  - Forceps- straight
  - Forceps- curved mosquito
  - Butterfly closure/Steri-strips

<table>
<thead>
<tr>
<th></th>
<th>Insertion</th>
<th>Removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterile fenestrated</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>surgical drape</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterile talc-free</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>gloves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Betadine swabs</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Sterile 4x4 gauze</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>sponges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1% Lidocaine</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>with/without</td>
<td></td>
<td></td>
</tr>
<tr>
<td>epinephrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syringe 5 cc</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>and needles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(18g 1-1 ½&quot;, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22g 1½”)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure bandage</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Co-flex dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterile scalpel</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>#11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forceps- straight</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Forceps- curved</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>mosquito</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Butterfly closure</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Steri-strips</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B. INDICATIONS
The single rod of 68 mg etonogestrel implant, a long acting, reversible contraceptive (LARC), is a good choice for any reproductive age woman (including teens) who desire the following:

1. A highly effective, rapidly reversible, long-term contraception (up to 3 years).
2. A form of hormonal contraception but cannot/should not use estrogen-containing contraception.

C. PRECAUTIONS AND CONTRAINDICATIONS
Medical conditions categorized as 3 or 4 in U.S. MEC.
For Category 3, the clinician will document client counseling of risks/benefits and reasons that the benefits outweigh the risk in the client medical record; for Category 4, do not provide the method.

D. HEALTH SCREENING/EXAM
1. Within the past 12 months, client must have on record a complete medical history as described in Section 1, Subsection 1.2.H.a Contraceptive Services.
2. Identify and record any allergies (particularly to betadine/iodine, latex, lidocaine or any component of the implant) since this may preclude the use of an implant.
3. Obtain a baseline weight/height, BMI and BP measurement for monitoring implant users over time.

E. COUNSELING & EDUCATION
The consent form and counseling handout can serve as the basic format for client education.
1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services.
2. During contraceptive counseling and before implant insertion, discuss the following with your client:
   • Efficacy: Less than 1 woman out of 100 becomes pregnant in the first year of the implant use.
   • Risks/benefits: Document the discussion in the client’s record.
   • Common side effects:
     o Infrequent spotting (34% of users)
     o Amenorrhea (22% of users)
     o Heavy or prolonged bleeding (18% of users)
     o Frequent bleeding (7% of users).
   Counseling about expected bleeding patterns and reassurance that bleeding irregularities and amenorrhea are generally not harmful will help reduce method discontinuation.

F. CONSENT
1. Before insertion/removal the consent form will be reviewed with the patient by the staff (nurse, medical assistant or clinician) providing counseling; clarified and signed by the clinician; and signed and dated by the client.
2. The original consent form is filed in the client’s record and a copy is given to the client.
G. INSERTION PROCEDURE (to be performed by trained/certified clinicians only)

1. The contraceptive implant will be inserted by a trained clinician. The FPP requires that clinicians attend the manufacturer’s training.
   - As a standard for new Title X PHO clinicians FPP accepts a minimum of 2 observed/supervised insertions and 2 removals to be eligible to perform these procedures independently.

2. **Insertion**: Identify the insertion site, which is at the inner side of the non-dominant upper arm. The insertion is overlying the triceps muscle about 8-10 cm (3-4 inches) from the medial epicondyle of the humerus and 3-5 cm (1.25-2 inches) posterior to the sulcus (groove) between the biceps and triceps muscles. This location is intended to avoid the large blood vessels and nerves lying within and surrounding the sulcus. If it is not possible insert the implant in this location, it should be inserted as far posterior from the sulcus as possible.

3. **Insertion Timing**: The implant can be inserted at any time if the clinician is reasonably certain that the client is not pregnant. See “How to Be Reasonably Certain that a Woman Is Not Pregnant”. For Special Considerations for Initiation, a clinician may refer to U.S. SPR.

4. **Need for Back-Up Contraception**:
   - If the implant is inserted within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
   - If the implant is inserted > 5 days since menstrual bleeding started, client needs to abstain from sexual intercourse or use existing/additional contraceptive for the next 7 days.

5. The medical record will include:
   - The client’s name, address, implant lot number, and name of inserting clinician in the Pharmacy Log.
   - The insertion date, implant lot number, and expiration date in the client’s medical record.

6. Give client a reminder card with removal date and numbers of the clinic during working hours or ER if wound infection or an acute problem occurs.

7. VISIT SCHEDULE FOR METHOD

   No routine follow-up visit is required although clients should be informed of the need for routine gynecological check-ups. Advise client to return:
   - At any time to discuss side effects or other problems.
   - If she wants to change the method being used.
   - When it is time to remove or replace the implant in 3 years.

   At other clinic visits, nurse/clinician seeing implant users should do the following:
   - Assess the client’s satisfaction with her contraceptive method and whether she has any concerns about method use.
   - Assess any changes in health status, including medications that would change the appropriateness of the implant for safe and effective continued use based on U.S. MEC (e.g., Category 3 and 4 conditions and characteristics).
   - Consider assessing weight changes and counseling clients who are concerned about weight changes perceived to be associated with their contraceptive method.

H. PROBLEM MANAGEMENT (FOR CLINICIANS)

All client calls regarding contraceptive implants should be handled by a nurse, who will refer problems to a clinician. Any client requesting removal will be scheduled for a counseling visit. Prior to removal of implant, the clinician may manage irregular bleeding (spotting, light bleeding, or heavy or prolonged bleeding) as follows:

- If clinically indicated, consider an underlying gynecological problem, such as interactions with other medications, an STD, pregnancy, or new pathologic uterine conditions (e.g., polyps or fibroids). If an underlying gynecological problem is found, treat the condition or refer for care.
- If an underlying gynecologic problem is not found and the client wants treatment, the
following treatment options during days of bleeding can be considered:
- NSAIDS for short-term treatment (5–7 days).
- Hormonal treatment (if medically eligible) with low-dose COCs for short-term treatment (10–20 days).
- If irregular bleeding persists and the client finds it unacceptable, counsel her on alternative methods, and offer another method if it is desired.

I. REMOVAL OF IMPLANT (to be performed by trained/certified clinicians only)

A woman may become pregnant immediately after implant removal. Sperm may live up to 5 days. If the woman has not already started a hormonal method or received an IUD, it is prudent to recommend abstinence or to use a barrier method starting 5 days before mid-cycle implant removal.

1. Product labeling states that the implant is to be used for no more than 3 years. Reasonable evidence shows that the implant is effective for longer. With appropriate counseling a patient may choose to keep her implant in for 4 years.
2. If the client requests removal at the end of 3 years, determine if she wishes to have another implant inserted at the time of removal. Provide counseling on other contraceptive methods if she doesn't want to replace the expired device with another implant.
3. If the client desires removal so she can seek pregnancy, remind her that contraceptive protection stops as soon as the device is removed. Counsel the client that she may wish to use spermicide and condoms as a method for one or two cycles so she can accurately date her pregnancy. Provide preconception counseling at the same time as the removal.
4. Other clients who request removal prior to 3 years will be given a counseling visit appointment with a clinician. This also applies to women who had the device inserted elsewhere but come to our clinic requesting removal. These women, however, must become enrolled as Family Planning clients before obtaining the removal service.
5. Removals will be performed only by clinicians approved for this procedure by the RHO. If your clinic doesn't provide removals, you must refer the client to a clinic that does. The consent form should be read and signed by the client.

J. RETURN OF UNUSED IMPLANT: The company may credit/exchange opened but unused devices. Contact the NM DOH Pharmacy at 505-476-8350 to report defective devices. The lot number will be required.

K. BROKEN IMPLANTS

Although infrequent, there have been occurrences of broken or bent implants while in the patient’s arm. When an implant is broken or bent, the rate of etonogestrel release may be slightly increased. This makes using a backup birth control method unnecessary. However, removal of the bent/broken implant is recommended, and the client should be advised of risks of unprotected intercourse prior to removal (see Subsection I, above). When implant replacement is decided, the clinician may insert a new implant immediately instead of waiting for the Merck replacement.

Merck Pharmaceutical Company, tracks all adverse events and product quality issues. When encountering a client with a broken or bent implant, clinician will:

STEP 1 Have the following information ready for making a notification:
- Implant lot number
- Insertion Date
- Removal Date
- Summary of both insertion and removal experiences, mention any trauma that occurred
- Provide Protected Health Information (PHI) ONLY if the client signs a release-of-information consent form.
- Merck requests return of the broken implant; retain the broken implant in a biohazard
STEP 2 Notify Merck National Service Center at 1-800-NSC-MERCK (1-800-672-6372), follow prompts to address product defect with their Quality Team. A case number will be assigned when the clinician calls and a form will be faxed to the clinician to sign and return to Merck. After the Merck Quality Team/customer services representative authorizes a Nexplanon replacement, direct her/him to contact the DOH Warehouse pharmacy at 505-476-8350. Merck must send all replacements to the DOH Pharmacy Warehouse, and not to PHO or PA clinics.

STEP 3 Notify NM DOH Pharmacy at 505-476-8350 and provide the following information:

- Name of clinician who inserted implant
- Date of insertion
- Implant lot number
- Case Number
CONTRACEPTIVE IMPLANT CONSENT FORM

BENEFITS: Contraceptive implants consist of one capsule that holds a small amount of birth control hormone, etonogestrel. This medicine is slowly released under my skin to help keep me from getting pregnant for 3 years. I understand that the contraceptive implant is over 99% effective.

RISKS: I understand that I should not use the contraceptive implant if I have any of the following conditions, which I do not have: pregnancy or active breast cancer. I understand that I may have changes in my menstrual bleeding. It may be irregular, lighter or heavier or my bleeding may completely stop. I am aware that some of the less common side effects include headaches, feeling more nervous, a little weight gain and depression. It is possible I may develop a tiny scar or infection at the insertion site.

I have been told that in order to lessen the chances of serious problems, it is my responsibility to contact a hospital emergency room, a doctor or this clinic if I start having any of the following symptoms: severe headaches, blurred vision or loss of vision, pain in legs, abdominal pain, chest pains, breast lump, severe depression, yellowing of skin, heavy vaginal bleeding, if I suspect I am pregnant, if I cannot feel the contraceptive implant rod under the skin in the arm where it was placed or if I have pain, pus or discomfort at the site of insertion.

I understand that the contraceptive implant does not protect against HIV and other sexually transmitted infections. I understand that I should use condoms consistently and correctly if there is any chance that I am infected or that I am having intercourse with someone who is infected.

I am aware that certain drugs may make the contraceptive implant less effective. These drugs are commonly used for treatment of seizures (epilepsy) and tuberculosis (TB). If I am under treatment with these or any other drugs, I will tell my clinician.

ALTERNATIVES: Other means of contraception have been explained to me.

INQUIRIES: I have been given the chance to get answers to my questions about this method and this consent form.

DECIDING TO STOP USING IMPLANON/NEXPLANON: I have the right to request that the contraceptive implant be removed at any time. I understand the capsule should be removed from my arm after it has been in place for three years. I understand that any care outside the health office for problems related to the contraceptive implant is at my own expense.

EXPLANATION OF PROCEDURE: I understand the capsule is inserted just under the skin of my upper arm. It will be placed with a narrow tube after cleaning my skin with an antiseptic and injecting local pain medicine. My arm will be bandaged for a one day and bruises may appear.

I understand the removal procedure is similar to placement. It consists of skin cleaning, the injection of pain medication and a small cut through which the capsule is removed with forceps. I understand that removal involves a small risk of infection or other complications; that it usually takes longer than insertion, and that bruising is common. In a few cases, two visits are needed to remove the capsule.

DOCUMENTATION: I have read and understand the information in this consent form. I have had all my questions about the contraceptive implant answered. I do not believe there is any chance I might be pregnant. I am aware that the contraceptive implant is not 100% effective but my chances of becoming pregnant while using it correctly are very low. (check whichever applies, and sign below)

___ I am voluntarily requesting the insertion of the contraceptive implant.
___ I am voluntarily requesting the removal of the contraceptive implant.

Client Name __________________ Date of Birth: ___________ Client Signature: ________________________________

Counselor Signature: ___________________ Date: __________________

Clinician Signature: ___________________ Date: __________________

(New Mexico Public Health Division - Family Planning –Contraceptive Implant Consent English 10/19)
DECLARACIÓN DE CONSENTIMIENTO INFORMADO PARA IMPLANTE ANTICONCEPTIVO

**BENEFICIOS**: El método anticonceptivo implante anticonceptivo se compone de una varilla que contiene una pequeña cantidad de la hormona etonogestrel. Esta hormona se va liberando despacio debajo de la piel y, de esta forma, me ayuda a no quedar embarazada durante tres años. He comprendido que implante anticonceptivo tiene una eficacia del 99%.

**RIESGOS**: He comprendido y sé que no debo usar implante anticonceptivo si tengo alguna de las siguientes condiciones médicas, que no tengo: embarazo, o cáncer de seno activo. He comprendido que puedo sufrir cambios en mi sangrado menstrual. Este puede ser irregular, más abundante, puede disminuir o, incluso, puede estar completamente ausente. He comprendido que algunos de los efectos secundarios menos común que se pueden presentar incluyen: dolor de cabeza, nerviosismo, un poco aumento de peso y depresión. Es posible que me deje una pequeña cicatriz o me produzca una infección en el lugar de inserción.

Me han informado que para reducir la posibilidad de que se produzcan complicaciones serias, es responsabilidad mía ponerme en contacto con la sala de emergencias de un hospital, un médico o con esta clínica si empiezo a tener algunos de los siguientes síntomas: dolor de cabeza grave, visión borrosa o pérdida de visión, dolor en las piernas, dolor abdominal, dolor en el pecho, nódulo mamario (bulto en los senos), depresión grave, ictericia, sangrado menstrual abundante, si creo que pudiera estar embarazada, si no puedo sentir el implante anticonceptivo bajo la piel en el lugar del brazo donde fue insertada, o si en el lugar de inserción tengo dolor, pus o molestia.

He comprendido que implante anticonceptivo no me protege contra el VIH ni otras infecciones de transmisión sexual, por lo que siempre debo usar condones de forma correcta si existe la posibilidad de que haya contraído cualquiera de estas enfermedades o de que tenga relaciones sexuales con alguien que las haya contraído.

Sé que ciertos medicamentos pueden reducir la eficacia de implante anticonceptivo. Estos medicamentos son los que se usan normalmente en el tratamiento de la epilepsia (convulsiones) y tuberculosis. Si estoy siguiendo tratamiento médico que requiere estos u otros medicamentos, debo decírselo a mi profesional médico.

**ALTERNATIVAS**: Se me han explicado otros métodos anticonceptivos.

**PREGUNTAS**: Se me ha dado la oportunidad de obtener respuestas a mis preguntas sobre este método y este formulario de consentimiento.

**SI DECIDO DEJAR DE USAR IMPLANTE ANTICONCEPTIVO**: Tengo derecho a solicitar la extracción de implante anticonceptivo en cualquier momento. He comprendido que el implante debe ser extraído de mi brazo cuando hayan transcurrido tres años desde su inserción. También comprendo que soy responsable del pago de cualquier atención médica que reciba fuera de la oficina de salud por problemas relacionados con implante anticonceptivo.

**EXPICACIÓN DEL PROCEDIMIENTO**: Entiendo que la varilla se inserta justo debajo de la piel de la parte superior de mi brazo. Se colocará con un aplicador en forma de tubo después de limpiar mi piel con un antiséptico e inyectarme analgésicos locales. Me vendrán el brazo por un día y pueden aparecer moretones.

Entiendo que el procedimiento de eliminación es similar al de inserción. Consiste en la limpieza de la piel, la inyección de analgésicos y un pequeño corte a través del cual se extrae la cápsula con pinzas. Entiendo que la eliminación implica un pequeño riesgo de infección u otras complicaciones; que usualmente toma más tiempo que la inserción, y que los moretones son comunes. En algunos casos, se necesitan dos visitas para extraer la cápsula.

**DOCUMENTACIÓN**: He leído y comprendido la información en esta declaración de consentimiento y se me han aclarado todas las dudas y preguntas que he planteado. No creo que exista ninguna posibilidad de que esté embarazada. Comprendo que la efectividad de implante anticonceptivo no es del 100% pero la posibilidad de quedar embarazada si lo uso correctamente es mínima.

Marque con una X su decisión y firme más abajo:

_______ Solicito de forma voluntaria la inserción de implante anticonceptivo.
_______ Solicito de forma voluntaria la extracción de implante anticonceptivo.

Nombre del cliente__________ Fecha de nacimiento: _______Firma del cliente: ___________________

Firma de la consejera o consejero ______________________________ Fecha: ______________

Firma de la clínica(o): __________________________________________ Fecha: ______________

(New Mexico Public Health Division - Family Planning –Contraceptive Implant Consent Spanish 10/19)
Contraceptive Implant

Counseling Handout

What is the contraceptive implant?
The contraceptive implant is made of one capsule that holds a small amount of birth control hormone, etonogestrel. This medicine is slowly released from the capsule to prevent pregnancy for up to 3 years. The implant is placed under the skin of the upper arm.

How does it work?
The hormone works by making cervical mucus thicker so sperm cannot reach the egg, by making the lining of the uterus thinner, and by stopping ovulation (release of egg).

How effective is it?
It is over 99% effective at preventing pregnancy.

What are the advantages?
- Decreased menstrual flow and anemia, menstrual cramps, endometriosis, pelvic inflammatory disease (PID), endometrial and ovarian cancer.
- Usually can be used by women who cannot use estrogen-containing methods.
- Nursing mothers can use the implant.
- Can be used by women who are over 35 years old and smoke.
- Ability to get pregnant returns quickly after removing the implant.

What are the disadvantages?
- Unpredictable, irregular bleeding is the most common problem. Talk to your provider if this is a problem; there are treatments that can help.
- Do not protect you from HIV or other sexually transmitted diseases. Use condoms if you are at risk.

Warning signs:
- Lower abdominal pain. This could be an ectopic pregnancy.
- Repeated, very severe headaches
- Heavy bleeding

Where do I get a contraceptive implant?
You can get a contraceptive implant from your doctor, nurse practitioner, nurse midwife or health department. Not all providers have this service. Call to find out if your provider can do it.

What if I have sex and don’t use birth control?
Call the office for Emergency Contraceptive Pills to prevent pregnancy up to 5 days after unprotected sex. You can also visit www.Not-2-Late.com for more information.
**Implante Anticonceptivo**

¿**Qué es el implante anticonceptivo?**
El implante anticonceptivos está hecho de una cápsula que contiene una pequeña cantidad de hormonas para controlar el embarazo, etonogestrel. Esta medicina se sale lentamente de la cápsula para prevenir embarazos por 3 años. El implante se coloca bajo la piel del antebrazo.

¿**Cómo trabaja?**
La hormona trabaja al hacer el moco del cuello de la matriz más espeso para que el esperma no pueda alcanzar al huevo, haciendo que la pared del útero se haga más delgada, y deteniendo la ovulación (la caída del huevo).

¿**Qué tan eficaz es?**
Es más de 99% eficaz para prevenir embarazos.

¿**Cuáles son sus ventajas?**
- El flujo de la menstruación se aminora, así como el riesgo de anemia, cólicos, endometriosis, hinchazón de la pelvis, (PID en inglés) y cáncer del endometrio y de los ovarios.
- Generalmente puede usarse por las mujeres que no pueden usar métodos que contengan estrógeno.
- Las madres que están dando pecho pueden usar el implante.
- Puede ser usado por mujeres que tienen más de 35 años y fuman.
- La habilidad de embarazarse regresa rápidamente después de que se remueve el implante.

¿**Cuáles son las desventajas?**
- El problema más común es sangrado irregular que no se puede predecir. Hable con su médico si esto es un problema, hay tratamientos que la pueden ayudar.
- No protege contra el VIH o de otras enfermedades transmitidas sexualmente. Use condones si usted está en riesgo de contraerlas.

Señales de problemas:
- Dolor en la parte baja del abdomen. Pudiera ser un embarazo ectópico.
- Dolores de cabeza repetidos, muy severos.
- Sangrado profuso.

¿**Dónde puedo conseguir un implante anticonceptivo?**
Usted puede conseguir un implante anticonceptivo de su doctor, de su enfermera titulada y certificada para recetar, de su partera o del Departamento de Salud. No todos los que proveen atención médica tienen este servicio. Llame para ver si quien le da atención médica lo tiene.

¿**Qué pasa si tengo sexo y no uso anticonceptivos?**
2.2 INTRAUTERINE DEVICES: IUDs

A. EQUIPMENT:

For teaching:
- Client counseling handout
- Copy of FP IUD Consent Form
- Calendar
- Plastic pelvis
- Sample IUD

For Insertion:
- Emergency tray
- Sterile IUD pack: uterine sound, tenaculum, ring forceps, scissors, long narrow forceps if available
- Sterile IUD
- Antiseptic solution (Chlorhexidine gluconate may be considered for betadine allergy. (ACOG Committee Opinion No. 571, Sept. 2013)
- Large OB swabs
- Sterile and non-sterile gloves

B. INDICATIONS

IUDs are long acting, reversible contraceptives (LARCs), and can be used by women of all ages, including teens, and both by parous and nulliparous women. Two types of IUDs are available in the FPP formulary: Copper IUD (Cu-IUD, Paragard) and IUD containing 52 mg levonorgestrel (Liletta LNG 52/5 or Mirena LNG 52/5). The Cu-IUD is FDA approved for 10 years while the Liletta (LNG 52/5) and Mirena (LNG 52/5) are FDA approved for 5 years respectively.

Cu-IUD is also highly effective as emergency contraception and can be continued as regular contraception (SPR, 2016). Women wanting a Cu-IUD as emergency contraception, and who meet the following guidelines (see algorithm in the “Insertion Timing” section below), can be considered candidates for this contraception option. Provision of Cu-IUD as emergency contraception is at the discretion of the clinician and provided on a case-by-case basis.

C. PRECAUTIONS AND CONTRAINDICATIONS

Medical conditions categorized as 3 or 4 in U.S. MEC.

For Category 3, the clinician will document client counseling of risks/benefits and reasons that the benefits outweigh the risk in the client medical record; for Category 4, do not provide the method.

D. HEALTH SCREENING/EXAM:

1. Within the past 12 months, client must have on record a complete medical history as described in Section 1, Subsection 1.2.H.a Contraceptive Services. History of last normal menses (LMP) and the previous normal menses (PMP), as well as recent and last unprotected intercourse (UPI) are crucial to determine client’s pregnancy risk. Document recent UPI that occurred since the client’s last normal menses.

2. Identify and record any allergies (particularly to betadine/iodine, latex, copper or any component of the selected IUD) since the latter may preclude the use of a particular IUD.

3. Obtain a baseline weight/height, BMI and BP measurement for monitoring IUD users over time.

4. Pre-insertion: Assure that the client’s record contains a negative chlamydia and gonorrhea test result within the last 12 months. According to US SPR recommendations, most women do not require additional STD screening at the time of IUD insertion – screen according to PHD STD screening guidelines; screening can occur at time of insertion. Women with current purulent cervicitis should not undergo IUD insertion until GC/CT infection has been
ruled out or treated; women with known GC or CT infection should not undergo IUD insertion."
A positive CT within the last 12 months does not preclude a woman from getting an IUD if she has been appropriately treated. (CDC STD guidelines: https://www.cdc.gov/std/tg2015/screening-recommendations.htm).

At the clinician’s discretion, the CT/GC test can be performed on the same day of insertion, if the clinic meets all the following criteria:

- Has an IUD available.
- Has a system in place to follow-up on the CT/GC lab results. (The clinician who decides to insert the IUD will ultimately take clinical responsibility to assure that the client’s lab is checked.)
- Has a clinician readily available to properly manage IUD clients with positive CT/GC test in a timely manner.

E. COUNSELING & EDUCATION

The consent form and counseling handout can serve as the basic format for client education.

1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services.

2. Include the following information during contraceptive counseling and before IUD insertion:

   - **Efficacy:** Less than 1 woman out of 100 becomes pregnant in the first year of using an IUD. The Cu-IUD is the most effective form of emergency contraception and can be continued as a contraceptive method after placement.
   - **Risks/benefits:** Counsel your patient about the risks and benefits of IUD use and insertion and document the discussion in the client’s record. Counseling about expected bleeding patterns and reassurance that bleeding irregularities and (for LNG-IUD) amenorrhea are generally not harmful will help reduce method discontinuation. Mirena (LNG 52/5) and Liletta (LNG 52/5) have similar drug delivery, concentrations and side effect profiles. With LNG-IUD use, heavy menstrual bleeding, dysmenorrhea, and endometriosis generally improves. Amenorrhea develops in approximately 20% of users by 1 year. (2017-2018 Managing Contraception, 14th Edition, p. 115-116). By the end of 3 years of use, 30-50 percent of LNG 52mg users report amenorrhea.
   - **Common side effects:** such as unscheduled spotting or light bleeding or heavy or prolonged menstrual bleeding, especially during the first 3–6 months of use.
   - **Pre-medication with non-steroidal anti-inflammatory drugs (NSAID):** Clients with a scheduled IUD insertion who do not have contraindications/allergy to NSAID may be instructed to take OTC naproxen sodium (220 mg) 2 tablets or ibuprofen (200 mg) 3-4 tablets by mouth one hour prior to the insertion. Trials of Naproxen and Tramadol have shown some effect in reducing IUD insertion pain. Other NSAIDs have not reduced insertion pain but may decrease post insertion cramping. (Lopez LM, Bernholc A, Zeng Y, et al. Interventions for pain with intrauterine device insertion. Cochrane Fertility Regulation Group. DOI:10.1002/14651858.CD007373.pub3).
   - Encourage client to review the Manufacturer’s brochure.

3. ECP information in the case of IUD expulsion.

F. CONSENT

1. Before insertion/removal the consent form will be reviewed with the patient by the staff (nurse, medical assistant or clinician) providing counseling; clarified and signed by the clinician; and signed and dated by the client.

2. The original consent form is filed in the client record and a copy is given to the client.
G. PROCEDURE/INSERTION TECHNIQUE

1. For PHOs, the RHO is responsible for determining which clinicians under his/her supervision are cleared to insert IUDs, and to provide Cu-IUD as emergency contraception up to 5 days after unprotected intercourse or based on their ability to determine ovulation. The level of proficiency in varying insertion situations (different uterine positions) should be the criterion for certification, rather than an absolute number requirement. For PHO clinicians, difficult IUD insertions or removals may be referred to UNM Center for Reproductive Health with prior approval of the FPP State Office.

   - As a standard for new Title X PHO clinicians, the FPP accepts a minimum of 5 supervised IUD insertions prior to clinician performing IUD insertions independently.

3. Insertion Timing: The Cu-IUD/LNg-IUD can be inserted at any time if the clinician is reasonably certain that the woman is not pregnant. For Special Considerations for Initiation of IUDs, a clinician may refer to U.S. SPR. If providing Cu-IUD as EC, the standard of care is to provide the Cu-IUD within 120 hours of the first act of unprotected sexual intercourse (SPR, 2016).

The following algorithm is modified from Reproductive Health Access Project October 2016 at www.reproductiveaccess.org. This is a clinician tool; however, some experienced nurses who are proficient in providing family planning services may find this helpful when scheduling clients for an IUD clinician visit.

4. Back-Up Contraception:
   - Cu-IUD is immediately effective and no back up contraception is needed after insertion.
   - For LNg-IUD,
     - If inserted within the first 7 days since menstrual bleeding started, no back up contraceptive is needed.
If inserted >7 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use back up contraceptive for the next 7 days.

5. Before inserting IUD,
   - Assure that the BP is documented in the client’s record.
   - The clinician will:
     - Perform a bimanual pelvic examination cervical inspection and sound the uterus for position and depth. Ensure that the uterine cavity is within the size range necessary for effective intrauterine contraception. Do not open the IUD kit until this step has been completed. Manufacturer recommendations for minimal and maximal uterine sounding vary by the type of IUD.
       - Cu-IUD cavity size range of 6-9 cm.
       - LNG IUD 52/5 (Mirena) should be limited to cavities 6-10 cm.
       - LNG IUD 52/5 (Liletta) gives a lower limit of 5.5 cm and leaves the upper length to the provider’s discretion.
     - Current purulent cervicitis, chlamydial or gonorrhea infection at the time of insertion are contraindications for IUD initiation (US MEC 4).
     - For clients with symptomatic abnormal vaginal discharge, the wet prep, pH and amine test is recommended. If bacterial vaginosis (BV) or trichomonas is diagnosed, you may still insert IUD and start treatment on the same visit (US MEC 2).
     - For asymptomatic clients with normal pelvic exam additional testing with wet prep, pH, and amine is at the clinician’s discretion.

H. POST-INSERTION

1. After procedure, allow client to rest briefly on exam table.

2. Allow client to sit up on exam table. When steady, client can stand. Teach the client how to check for strings. Routine self-string IUD checks are safe but not necessary. Many women are uncomfortable with checking their own strings. They may also be unable to feel the strings. For those who are interested offer her the cut fragment of the strings so she can get a sense of what the string should feel like.

3. Allow client to get dressed.

4. Post-insertion problems: Severe post insertion pain, vasovagal reaction, syncope, seizures and even cardiac arrest (very rare) may occur immediately post insertion. If the client is dizzy, faint or in significant pain, she should rest in a supine position, away from hard or sharp surfaces. The client should sit or lie where she can be observed. No client should be allowed to leave the clinic feeling faint, dizzy or with continuing significant pain.
   - If the client experiences vasovagal reaction (pulse rate drops below 60, with a fall in BP), stop the procedure and place the patient in the supine position with her legs elevated. If she does not respond to conservative measures, clinician may consider removing the IUD.
   - If seizures or cardiac arrest occur (very unlikely), clinic staff will follow the clinic’s medical emergency protocols.

5. The medical record will include:
   - Post-insertion BP (and pulse only if patient has a vasovagal episode).
   - The client’s name, address and IUD lot number in the Pharmacy log.
   - The insertion date and type of IUD in the client record; include the IUD Lot # and expiration date.
   - Review of danger & problem symptoms/signs (PAINS-see IUD counseling handout) e.g., for infection and ectopic pregnancy. If needed, supply with condoms for backup and STD prevention.
I. FOLLOW UP VISIT

Routine follow-up visit is not required for all clients, but she should continue with her routine gynecological check-ups. Specific populations like adolescents, women with multiple problems or previous expulsion may benefit from a scheduled follow-up visit.

Advis client to return:
- Anytime she wants to discuss side effects or other problems or desires to discontinue the method. Offer her a follow-up visit 1-3 months after initiating the IUD if she so desires.
- When it is time to remove/replace the IUD (removal date reminder card is available in the package). Both Mirena and Liletta have FDA approval for 5 years. Cu-IUD has FDA approval for 10 years. At end of 5th year for LNG-IUD after insertion and at end of 10th year for Cu-IUD, clients who wish to continue using IUD should have replacement and consent.

At other clinic visits, nurse/clinician who sees IUD users should do the following:
- Assess the client’s satisfaction with her contraceptive method and whether she has any concerns about method use.
- Assess any changes in health status, including medications that would change the appropriateness of the IUD for safe and effective continued use on the basis of U.S. MEC (e.g., category 3 and 4 conditions and characteristics).
- Consider assessing weight changes and counseling women who are concerned about weight changes perceived to be associated with their contraceptive method.
- Clinician-consider performing an examination to check IUD strings.

J. VISIT SCHEDULE FOR METHOD

IUD users with problems should schedule to see a clinician who will provide appropriate and timely management or referral.

K. PROBLEM MANAGEMENT (FOR CLINICIANS)

The image below demonstrates the fertile window (-5 to +1 days from ovulation, in women with regular 28-day cycles) that a clinician can use as a reference to determine a client’s risk of pregnancy when considering provision of Cu-IUD as EC. (Wilcox, et al. New Engl J Med. 1995;33(23):1517-1521).
The following practice guidelines are from the U.S. Selected Practice Recommendations for Contraceptive Use 2016 (SPR).

1. WHEN AN IUD USER IS FOUND TO HAVE PID
   - Treat the PID according to the CDC STD Treatment Guidelines.
   - Provide comprehensive management for STIs, including counseling about condom use.
   - The IUD does not need to be removed immediately if the client desires contraception.
   - Reassess the client in 48-72 hours. If no clinical improvement occurs, continue antibiotics and consider removal of the IUD unless PID has occurred in the setting of suspected or known actinomyces colonization.
   - If the client wants to discontinue use, remove the IUD sometime after antibiotics have been started to avoid the potential risk for bacterial spread resulting from the removal procedure. (Tepper NK, Steenland MW, Gaffield ME, et al. Retention of intrauterine devices in women who acquire pelvic inflammatory disease: a systematic review. Contraception 2013;87:655–60).
U.S. SPR Downloads and Resources: Management of the IUD when a Cu-IUD or an LNG-IUD User is Found to Have Pelvic Inflammatory Disease

2. WHEN AN IUD USER IS FOUND TO HAVE BLEEDING IRREGULARITIES
   - Women should be counseled about irregular bleeding patterns related to the different IUD use and what is considered normal. Anticipatory guidance and counseling can improve method satisfaction and continuation.
   - Clients can have irregular bleeding immediately post insertion, in the first 3-6 months after insertion or after 6 months post IUD insertion.
     o Immediate post insertion bleeding – Bleeding related to the tenaculum site or insertion. It can present as light to moderate bleeding and can last 1 or a few days. This bleeding can blend in to the irregular bleeding pattern that can occur with certain IUDs in the first 3-6 months of use.
     o Early post insertion bleeding – Bleeding can be light, moderate or heavy and short or prolonged after insertion of either type of IUD. If the bleeding is bothersome encourage your client to return to the clinic for evaluation.
     o Anytime post insertion bleeding – In general bleeding patterns will improve and become more consistent after 6 months of use. Encourage clients to return for evaluation if new abnormal bleeding patterns develop or for persistent bleeding.
   - If clinically indicated, consider an underlying gynecological problem, such as IUD displacement, an STD, pregnancy, or new pathologic uterine conditions (e.g., polyps or fibroids), especially in women who have already been using the IUD for a few months or longer and who have developed a new onset of heavy or prolonged bleeding. Additionally,
consider the possibility of an expulsion. If an underlying gynecological problem is found, treat the condition or refer for care.

- For Cu-IUD user, if a GYN problem is not found and the client requests treatment, short-term NSAID use (5–7 days) can be considered during days of bleeding.

3. WHEN AN LNG-IUD USER IS FOUND TO HAVE AMENORRHEA

- Provide reassurance. Amenorrhea does not require any medical treatment. The Cu-IUD does not cause amenorrhea.
- If a client’s regular bleeding pattern changes abruptly to amenorrhea, consider ruling out pregnancy if clinically indicated.

4. WHEN IUD STRINGS ARE NOT SEEN DURING ROUTINE EXAMS

- Attempt to withdraw strings from endocervical canal with cytobrush/alligator forceps/etc.
- If unable to visualize the IUD strings after these attempts, perform pregnancy testing, provide a backup contraception, and refer the client for ultrasound.
- If the IUD is located by ultrasound, and the client would like to continue the method, document this and provide reassurance to client.
- If the IUD is not located, or the client would like her IUD removed, refer her to OB/GYN/clinician.

5. WHEN AN IUD USER IS FOUND TO BE PREGNANT

- Evaluate for possible ectopic pregnancy (perform gentle abdominal/pelvic exam and refer for ultrasound).
- Once an intrauterine pregnancy is confirmed, advise the client that she has an increased risk for spontaneous abortion (including septic abortion that might be life threatening) and of preterm delivery if the IUD is left in place. The removal of the IUD reduces these risks but might not decrease the risk to the baseline level of a pregnancy without an IUD. Earlier removal is associated with lower risk of miscarriage.
- If she does not want to continue the pregnancy, counsel her about options.
- If she wants to continue the pregnancy, refer the client to an OB/GYN at the earliest possible for IUD removal and management.

6. WHEN AN IUD USER IS FOUND TO HAVE ACTINOMYCES ON CYTOLOGY TEST REPORT

Lippes found that 3-4% of cultures from asymptomatic women both with and without an IUD were positive for Actinomycosis. This condition may be suggested by a Pap smear report of “Actinomycosis-like organism.” Less than half of women with such Pap smear reports have actinomycoses and those that do usually have asymptomatic colonization only. However, if an upper genital tract infection is present, it can be severe.

Clinician will examine clients with Actinomycoses/Actinomycosis-like organism on Pap report for any sign of PID (upper genital tract infection), which can be unilateral.

- If the client has PID symptoms, fever, severe pain, or an abscess is suspected, consult with RHO and refer to a gynecologist. The PID caused by this organism is very serious and requires IUD removal and prolonged IV penicillin therapy.
- If the client has no evidence of upper genital tract involvement, counsel the client that Actinomycoses are bacteria that can be found in healthy humans and prefers to grow on foreign bodies such as IUDs.
- Clinical considerations:
  1) Actinomycoses-like organisms on a pap smear does not predict clinical illness.
  2) Actinomycoses species is considered normal flora of female genital tract.
  3) Pelvic actinomycosis infection is very rare, serious, and poorly understood.
  4) If asymptomatic, nothing is done simply observe.
  5) If symptomatic, do bimanual exam to assess pelvic infection. If patient has signs or symptoms of clinical infection, then remove IUD, because this bacterium preferentially
grows on foreign bodies, and send for culture (this option may not be available at your clinic, clinician should use their discretion if referral is necessary). Provide backup contraception. This is usually found in long term IUD users and in those >35 years of age. (Contraceptive Technology 20th Revised Edition, Hatcher, et al.). Treatment may consist of oral Penicillin G 500mg QID for 30 days, Doxycycline 100mg BID for 30 days, or Amoxicillin/clavulanate 500mg BID for 30 days. (Obstet Gynecol Sci. 2014 Sep; 57(5): 393-396).

L. REMOVAL OF THE IUD (to be done by clinician)
The IUD should be removed any time the client requests removal, to switch to a different method or when the method is at the end of its active duration.
1. If the client has had sexual intercourse since the start of her current menstrual cycle and it has been >5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A health care provider may consider any of the following options:
   • Advise the client to abstain from sexual intercourse or use barrier contraception for 7 days before removing the IUD and switching to the new method.
   • If the client cannot return for IUD removal and has not abstained from sexual intercourse or used barrier contraception for 7 days, advise the woman to use ECPs at the time of IUD removal.
2. If the client is switching to an Implant/DMPA advise the woman to retain the IUD for at least 7 days after the implant is inserted and return for IUD removal.
3. The IUD may be removed by a clinician for reasons including those below:
   a. The client wishes it to be removed;
   a. Pain or bleeding problems;
   b. Current PID with no clinical improvement after 48-72 hours of proper antibiotic treatment;
   c. Partial expulsion of the device;
   d. Desires pregnancy (offer pre-pregnancy counseling);
   e. IUD needs replacement per manufacturer’s recommendations.

M. MANAGEMENT OF OTHER IUDs
Follow manufacturer’s recommendations for removal schedule. Kyleena is approved for 5 years and Skyla is approved for 3 years. For women who have had an IUD inserted in another country and don’t know when it should be removed, discuss the option of removing the IUD and replacing it with a LNG or Cu-IUD.

N. IUD RETURN POLICY

Returning Unused Paragard: Contaminated or opened then dropped/not used Paragard IUDs may be replaced by the manufacturer. Contact the NM DOH Pharmacy at 505-476-8350 to report the incident as soon as possible. Maintain the package information so that lot number, etc. can be provided as needed. Follow the instructions given by NM DOH Pharmacy staff.

Replacing Used Paragard: Used IUD will be replaced if the Paragard IUD has been expelled or removed for medical reasons within 90 days of insertion. (The used IUD is not to be returned under these circumstances.) Contact the NM DOH Pharmacy at 505-476-8350 to report these situations as soon as possible. Maintain the package information so that lot number, etc. can be provided as needed. NM DOH Pharmacy Staff will instruct you on next steps.

The manufacturer will not replace an IUD used by a client for more than three months. This rule applies even if the client develops an intrauterine infection with the IUD and it needs to be removed for unsuccessful treatment or client desires.

If NM DOH Pharmacy Staff instructs you to contact the Paragard Manufacturer, and the Paragard device was expelled or removed, you may give them the information needed to complete their
“adverse reaction report” but do not provide the client’s name. They will ask date of insertion, lab results, medications, and details of what happened. The nurse or clinician can report the needed information from the client’s chart as long as the client is not identified.

**MIRENA:** Replacements are handled at the discretion of the local representative on an individual basis. Examples of eligible returns are the device fails to deploy or unable to pass the insertion tube through the cervical os. Contact the State Pharmacy Warehouse at 505-476-8350 to request a replacement.

**LILETTA:** Manufacturer may replace IUD if they are notified within thirty (30) days that unit: (1) was removed from sterile packaging and contaminated pre-insertion without coming into contact with a patient; (2) came into contact with a patient but insertion was unsuccessful; (3) was inserted successfully but was expelled or removed for medical reasons; (4) is considered to have a product quality problem. All return requests should first go through NM DOH Pharmacy at 505-476-8350.
PARAGARD INTRAMAMAL DEVICE (IUD) Consent Form

**BENEFITS:** I am voluntarily choosing to use an intrauterine device (IUD) as a method of family planning. I am aware that the IUD is NOT guaranteed to be 100% effective, but can be 99% effective if used correctly, however, depending on the number and timing of unprotected intercourse episodes in a menstrual cycle there may be a risk of undiagnosed pregnancy. (client initials)

**RISKS:** I realize that I should not use the IUD if I have any of the following conditions, which I do not have: a distorted uterine cavity, pregnancy, current chlamydial or gonococcal infection, pelvic tuberculosis, unexplained vaginal bleeding, or active breast, cervical, uterine or endometrial cancer (client initials). I am aware that while using an IUD I may have the following side effects: longer and heavier periods, cramping during or after insertion of the device, more cramping during my periods. I understand that I may be responsible for any cost related to complications resulting from using the method I choose.

IUDs may be associated with infections of the uterus or tubes. In addition, I have been told that IUDs may be associated with more serious complications such as puncturing the uterus, abscesses and bloodstream infections (sepsis). This may sometimes lead to ectopic pregnancy, sterility or death. Infection can be more serious if I am pregnant, and I know I should seek medical attention immediately if I think I am pregnant. If a pregnancy occurs when you have an IUD in place, there is a higher risk of miscarriage. I have been told that in order to lessen the chance of serious complications from my IUD, it is my responsibility to return to a clinic, a doctor or a hospital emergency room if I start having any of the following:

- Period late, no period
- Symptoms of pregnancy (fatigue, nausea, breast swelling/tenderness, frequent urination, weight gain)
- Abdominal pain or cramps
- Increased temperature, fever, chills
- Unusual or abnormal discharge
- Cannot feel IUD string, strings shorter or longer
- Can feel the plastic part
- See that the IUD has come out
- Spotting, bleeding, heavy periods, clots.

I understand that the IUD does not protect against HIV/AIDS and other sexually transmitted infections. I understand that I should use condoms consistently and correctly if there is any chance that I am infected or that I am having intercourse with someone who is infected.

**ALTERNATIVES:** The other means of birth control have been explained to me.

**DECISION TO DISCONTINUE:** I have been told that I may have an IUD removed if I want it removed without losing benefits under any government program. I understand that a woman is most likely to get pregnant if she and her partner do not use any birth control method. The health risks from pregnancy are greater than the health risks of using any birth control method.

**INSTRUCTIONS:** Instructions for using the IUD have been given to me and I have been given the patient labeling information. I understand how the IUD is inserted. I have been taught how to check for the strings of my IUD. I have been given manufacturers information about the IUD and I will read it.

**QUESTIONS:** I have been given the chance to ask questions about the IUD and about the consent form.

(Check whichever applies, and sign below)

I am voluntarily requesting the insertion of Paragard for:

- ___ on-going contraception.
- ___ emergency contraception and on-going contraception.
- ___ I am voluntarily requesting the removal of Paragard.

Client name: ___________________________ Date of Birth: __________ Client signature: _______________

Counselor signature: ______________________ Date: ______________

Clinician Signature: ______________________ Date: ______________

(New Mexico Public Health Division - Family Planning - Paragard IUD Consent English Rev. 10/19)
FORMULARIO DE CONSENTIMIENTO DEL DISPOSITIVO INTRAUTERINO (DIU) PARAGARD

BENEFICIOS: Escojo voluntariamente el dispositivo intrauterino (DIU) como método de planificación familiar. Entiendo que el dispositivo intrauterino NO se garantiza de ser 100% eficaz, pero puede tener una eficacia de 99% si se usa debidamente, sin embargo, dependiendo del número y el tiempo de los episodios de relaciones sexuales sin protección en un ciclo menstrual, puede que haya riesgo de embarazo no diagnosticado. _____ (iniciales del cliente)

RIESGOS: Comprendo y sé que no debo usar el DIU si tengo alguna de las siguientes condiciones médicas, de las cuales no tengo: cavidad uterina distorsionada, embarazo, clamidia, gonocócica, tuberculosis pélvica, sangrado vaginal sin diagnóstico, cáncer de cuello de útero, cáncer del útero o cáncer de endometrio activo _____ (iniciales del cliente).

Comprendo que al usar el DIU como método de planificación familiar, puedo tener los siguientes efectos secundarios: la regla dura más días y flujo menstrual más pesado, dolores agudos en la matriz durante y después que se inserte el dispositivo, y más cólicos durante mi regla menstrual. Comprendo que yo podría ser responsable por cualquier costo relacionado con las complicaciones que resulten del uso del método que yo escoja.

Los dispositivos intrauterinos (DIU) pueden ser asociados con infecciones de la matriz y las trompas de Falopio. Además, se me ha informado que el DIU puede causar complicaciones más serias como la perforación del útero, abscesos e infecciones en la sangre (sepsis). Es posible que esto pueda resultar en un embarazo ectópico, esterilidad o muerte. Las infecciones pueden ser más serias si estoy embarazada y sé que debo buscar atención médica inmediatamente si creo que estoy embarazada. Si un embarazo ocurre cuando tiene el DIU en su lugar, hay un mayor riesgo de aborto espontáneo.

Se me ha informado que para reducir la posibilidad de complicaciones serias del DIU, es mi responsabilidad regresar a una clínica, un doctor/a o una sala de emergencia de un hospital si empiezo a sentir cualquiera de los siguientes síntomas:

- La regla me viene tarde, o no tengo una regla menstrual
- Síntomas de embarazo (fatiga, náusea, hinchazón/sensibilidad en los senos, aumento en las ganas de orinar, aumento de peso)
- Dolor en el vientre o calambres
- Calentura, fiebre, escalofríos
- Cualquier flujo vaginal extraordinario o anormal
- No puedo tocar los hilos del DIU, están más largos o más cortos
- Puedo tocar la parte de plástico
- Veo que el DIU se ha salido
- Gotas o manchas de sangre, sangrando demasiado, coágulos

Comprendo que el dispositivo intrauterino no protege contra el VIH/SIDA u otras infecciones de transmisión sexual. Comprendo que debo usar condones continua y correctamente si hay posibilidad de que esté infectada o de que yo tenga relaciones sexuales con alguna persona que esté infectada.

ALTERNATIVAS: Se me ha informado de los otros métodos anticonceptivos.

DECISION DE DISCONTINUAR: Se me ha informado que se me puede retirar mi DIU si quieró que se me retire, sin perder los beneficios de cualquier programa del gobierno. Comprendo que es más probable que una mujer se embarace si ella y su compañero no usan ningún método anticonceptivo. Los riesgos de embarazo a su salud son mayores que los riesgos a su salud de usar cualquier método anticonceptivo.

INSTRUCCIONES: Se me han dado las instrucciones para el uso del DIU y se me ha dado la información de la etiqueta para pacientes. Sólo cómo se inserta el DIU. Me han enseñado como revisar los hilos de mi DIU. Se me ha dado la información de los fabricantes del DIU y la voy a leer.

PREGUNTAS: Se me ha dado la oportunidad de hacer preguntas acerca de este formulario de consentimiento.

(Marque con una X su decisión y firme debajo:)
Solicito de forma voluntaria la inserción de Paragard (DIU) como:
_____ método anticonceptivo de acción prolongada
_____ método anticonceptivo de emergencia y anticonceptivo de acción prolongada
______ Solicito de forma voluntaria la extracción de Paragard (DIU).

Nombre: _______________________ Fecha de nacimiento: ________ Firma de la cliente: ____________________
Firma de la consejera o consejero: __________________________________________Fecha: _________________
Firma de la clínica(o) : ________________________________________________________Fecha:  _________________

(New Mexico Public Health Division - Family Planning - Paragard IUD Consent Spanish Rev. 10/19)
LEVONORGESTREL (LNg) INTRAUTERINE DEVICE (IUD)
Consent Form

BENEFITS: I am voluntarily choosing to use a Levonorgestrel (Mirena or Liletta) intrauterine device (LNg IUD) as a method of family planning. I am aware that LNg IUD is very effective with 1 out of 100 women getting pregnant while using this method.

RISKS: I realize that I should not use the IUD if I have any of the following conditions, which I do not have:
- a distorted uterine cavity, pregnancy, current chlamydial or gonococcal infection, pelvic tuberculosis, unexplained vaginal bleeding, or active breast, cervical, uterine or endometrial cancer ___ (client initials). I am aware that while using LNg IUD as a method of family planning, I may have the following side effects:
  - changes in menstrual periods especially in the first 6 months, which may include higher number of bleeding or spotting days; cramping during or after insertion of the system; and/or increased chance of benign cysts on ovary, which do not require treatment or removal of the LNg IUD. I understand that I may be responsible for any cost related to complications resulting from using the method I choose.

I understand that LNg IUD does not protect against HIV and other sexually transmitted infections. I understand that I should use condoms consistently and correctly if there is any chance that I am infected or that I am having intercourse with someone who is infected.

IUDs may be associated with infections of the uterus or tubes. In addition, I have been told that IUDs may be associated with serious rare complications such as puncturing the uterus (less than 1 in a 1000). Infection can be more serious if I am pregnant, and I know I should seek medical attention immediately if I think I am pregnant. If a pregnancy occurs when you have an IUD in place, there is a higher risk of tubal pregnancy or miscarriage.

I have been told that to lessen the chance of serious complications from my LNg IUD, it is my responsibility to return to a clinic, a doctor or a hospital emergency room if I start having any of the following symptoms:
- Pregnancy symptoms
- Abdominal pain
- Increased temperature, fever, chills
- Unusual or abnormal vaginal discharge
- Cannot feel IUD string, or notice greatly increased or decreased string length
- Can feel the plastic part
- See or feel that the IUD has come out
- Spotting, bleeding, heavy periods, clots
- Develop severe or migraine headaches.

ALTERNATIVES: Other means of birth control have been explained to me.

DECISION TO DISCONTINUE IUD: I have been told that I may have the IUD removed if I want it removed without losing benefits under any government program. I understand that a woman is most likely to get pregnant if she and her partner do not use any birth control method. The health risks from pregnancy are greater than the health risks of using any birth control method.

INSTRUCTIONS: Instructions for using the IUD have been given to me and I have been given the patient labeling information. I understand how the IUD is inserted. I have been taught how to check for the strings of my IUD. I have been given manufacturers information about the IUD and I will read it.

QUESTIONS: I have been given the chance to ask questions about Mirena and about the consent form.

________________________________________________________
(Check whichever applies, and sign below)

____ I am voluntarily requesting the insertion of LNg IUD.
____ I am voluntarily requesting the removal of LNg IUD.

Client name: __________________________ Date of birth: ______ Client signature: __________________________

Counselor signature: __________________________ Date: __________________________

Clinician Signature: __________________________ Date: __________________________

(New Mexico Public Health Division - Family Planning – LNg IUD Consent English 10/19)
FORMULARIO DE CONSENTIMIENTO DEL DISPOSITIVO INTRAUTERINO (DIU) LEVONORGESTREL (LNg)

**BENEFICIOS:** Decido voluntariamente usar el dispositivo intrauterino (DIU) Levonorgestrel (LNg) como un método de planificación familiar. Estoy informada que el DIU LNG es muy efectivo con 1 de cada 100 mujeres quedando embarazadas mientras utilizan este método.

**RIESGOS:** Comprendo y sé que no debo usar el DIU si tengo alguna de las siguientes condiciones médicas, de las cuales no tengo: cavidad uterina distorsionada, embarazo, clamidia, gonocócica, tuberculosis pélvica, sangrado vaginal sin diagnóstico, cáncer de cuello de útero, cáncer del útero o cáncer de endometrio activo _____ (iniciales del cliente).

Comprendo que mientras esté usando el DIU LNG como un método de planificación familiar, puedo tener los siguientes efectos secundarios: cambios en los períodos menstruales especialmente en los primeros 6 meses, que puede incluir: sangramiento más pesado de lo normal o manchado; calambres durante o después de la introducción del dispositivo; y/o mayor probabilidad de tener quistes benignos en el ovario que no requieran tratamiento o la eliminación del DIU LNG. Comprendo que puedo ser responsable de cualquier costo relacionado con las complicaciones que resulten al usar el método que escogí.

Comprendo que el DIU LNG no protege contra el VIH u otras enfermedades de transmisión sexual. Comprendo que debo usar condones continuo y correctamente si hay la posibilidad de esté infectada o de tener relaciones sexuales con una persona que esté infectada.

El DIU se puede asociar con infecciones del útero o de las trompas de Falopio. Además, se me ha informado que el DIU se puede asociar con complicaciones más graves como la perforación del útero (menos en 1 de cada 1000). La infección puede ser más grave si estoy embarazada y sé que debo buscar atención médica inmediatamente si creo que estoy embarazada. Si un embarazo ocurre mientras tiene el DIU en posición, hay un mayor riesgo de embarazo ectópico o aborto espontáneo.

Comprendo que para reducir la posibilidad de complicaciones serias del DIU LNG, es mi responsabilidad regresar a una clínica, un doctor/a o una sala de emergencia de un hospital si comienzo a sentir cualquiera de los siguientes síntomas:

- Síntomas de embarazo
- Dolor en el vientre
- Calentura, fiebre, escalofríos
- Cualquier flujo vaginal extraordinario o anormal
- No puedo tocar el hilo del DIU, o están más largos o más cortos
- Puedo tocar la parte de plástico
- Veo que el DIU se ha salido
- Gotas o manchas de sangre, demasiado sangrando, coágulos
- Desarrollo severos dolores de cabeza (migraña).

**ALTERNATIVAS:** Se me ha informado de otros métodos anticonceptivos.

**DECISIÓN DE DISCONTINUAR EL DIU:** Se me ha informado que se me puede retirar el DIU si quiero, sin perder los beneficios de cualquier programa del gobierno. Comprendo que es más probable que una mujer quede embarazada, si ella y su compañero no usan ningún método anticonceptivo. Los riesgos a su salud por embarazo son mayores que cualquier riesgo de usar cualquier método anticonceptivo.

**INSTRUCCIONES:** Se me han dado las instrucciones para el uso del DIU LNG y se me ha dado la información de la etiqueta para pacientes. Sé cómo se inserta el DIU. Me han enseñado cómo revisar los hilos de mi DIU. Se me ha dado la información de los fabricantes del DIU y las voy a leer.

**PREGUNTAS:** Se me ha dado la oportunidad de hacer preguntas acerca de este formulario de consentimiento.

(Marque con una X su decisión y firme más abajo:)

_______ Solicito de forma voluntaria la inserción del DIU LNG.
_______ Solicito de forma voluntaria la extracción de DIU LNG.
Nombre: _______________________ Fecha de nacimiento: ________ Firma de la cliente: ____________________
Firma de la consejera o consejero: __________________________________________ Fecha: _________________
Firma de la clínica(o): ______________________________________________________ Fecha: _________________

(New Mexico Public Health Division – Family Planning – LNG IUD Consent Spanish 10/19)
**WHAT IS THE PARAGARD (COPPER T) IUD?**

An IUD is a small device which is placed inside the uterus. The vertical and horizontal arms of the Copper T 380A IUD contain copper. IUDs work mainly by preventing sperm from fertilizing ova (egg). Copper is slowly released into the uterine cavity. Copper is toxic to sperm and ova, decreasing the movement and survival of sperm—it keeps the sperm from fertilizing the egg.

**What are the Advantages of the Copper T IUD?**

* It is one of the most effective methods of birth control.
* It is reversible. It can be taken out of the uterus.
* It works for at least 10-12 years.
* It reduces risk of ectopic pregnancies.
* It is convenient, safe, and private.
* It may be used by women who cannot use birth control pills with estrogen.
* You can use it while you are breastfeeding.
* You can have one put in right after having your baby or after an abortion.
* Some studies have found a decreased risk for uterine cancer.

**What are the disadvantages of the Copper T IUD?**

* There may be cramping, pain or spotting after you have one put in. You may have some increased cramping during your period.
* You may bleed for more days than normal. (If your bleeding pattern bothers you, contact your clinic. You may be able to get medicine for this.)
* It doesn’t protect you against sexually transmitted infections. (Use condoms if there is any risk.)
* A small number of women are allergic to copper.
* Some men can feel the IUD strings during sex.
* Some women who use IUDs have a higher risk of pelvic inflammatory disease in the first month after you have one put in.

Before you leave the clinic, you should be able to feel the string. To do this you put one finger in the vagina while you are in a squatting position. You will feel your cervix, which is smooth and round and feels like the tip of your nose, with the strings of the device emerging from the center. If you feel the device itself, it is not in the proper place and you need to come into the clinic. If you do not feel the strings, you may not be protected. The IUD can be expelled without knowing it. Do not pull on the strings.

**Early IUD danger signs**

- **P-** Period late (pregnancy), abnormal spotting or bleeding
- **A-** Abdominal pain, pain with intercourse
- **I-** Infection exposure (such as Chlamydia and Gonorrhea), abnormal discharge
- **N-** Not feeling well, fever, chills
- **S-** String missing, shorter or longer

**Where do I get an IUD?**

You can get an IUD from your doctor, nurse practitioner, nurse midwife or health department. Not all providers have this service. Call to find out if your provider can do it.

**What if I have sex and don’t use birth control?**

Call the office for Emergency Contraceptive Pills to prevent pregnancy up to 5 days after unprotected sex. You can also visit [www.Not-2-Late.com](http://www.Not-2-Late.com) for more information.
WHAT IS THE MIRENA or Liletta (Levonorgestrel-LNg) IUD?

An IUD is a small device which is placed inside the uterus. The Mirena or Liletta IUD contains a progestin hormone called levonorgestrel (LNG). The LNG hormone in the IUD causes the cervical mucus to become thicker so sperm cannot reach the egg, suppresses the lining of the uterus and decreases sperm function. It may also suppress the ability of the ovary to release an egg.

What are the advantages of the Mirena or Liletta IUD?
* It is one of the most effective reversible methods ever developed.
* It prevents ectopic pregnancies and pelvic inflammatory disease.
* It decreases menstrual cramping.
* It decreases menstrual blood loss. Some women have no menstrual bleeding after one year.
* It may be left in place for up to 5 years based on FDA approval.
* IUD is safe and inexpensive over time.
* Once the LNG IUD is removed, you can get pregnant right away.

What are the disadvantages of the Mirena or Liletta IUD?
* It may change the menstrual cycle. There may be more bleeding days than normal for the first few months. There may be less bleeding days than normal after 6 to 8 months and sometimes your period can stop altogether. The bleeding pattern change may bother you. If it does, contact your clinician. There are medications which can help you have a better pattern of bleeding.
* The IUD does not protect you from sexually transmitted infections (STIs). You need to use condoms to protect yourself from STIs.
* Some women who use IUDs have a higher risk of pelvic inflammatory disease in the first month after you have one put in.

Before you leave the clinic, and if you are comfortable with it, we encourage you to feel the strings. To do this you put one finger in the vagina while you are in a squatting position. You will feel your cervix, which is smooth and round and feels like the tip of your nose, with the strings of the device emerging from the center. If you feel the device itself, it is not in the proper place. If you do not feel the strings, you may not be protected. Use back up contraception and come in to the clinic to be seen. The IUD can be expelled without your knowing it. Do not pull on the strings.

Signs and symptoms to watch for:
- **P** - Period late (pregnancy), abnormal spotting or bleeding
- **A** - Abdominal pain, pain with intercourse
- **I** - Infection exposure (such as Chlamydia and Gonorrhea), abnormal discharge
- **N** - Not feeling well, fever, chills
- **S** - String missing, shorter or longer

Where do I get an IUD?
You can get an IUD from your doctor, nurse practitioner, nurse midwife or health department. Not all clinicians offer this service. Check in advance.

What if I have sex and don't use birth control?
Call the office for Emergency Contraceptive Pills to prevent pregnancy up to 5 days after unprotected sex. You can also visit www.Not-2-Late.com for more information.
DIU de cobre

¿Qué es el DIU T de cobre?
El dispositivo intrauterino (DIU) es un pequeño aparato en forma de T que se coloca dentro del útero. Los brazos de la T contienen cobre. El cobre se va liberando lentamente en la cavidad uterina. El cobre impide que el esperma vaya desde el útero hasta las trompas y reduce la posibilidad de que fertilice el óvulo o de que el óvulo fertilizado se implante en el revestimiento del útero.

¿Cuáles son las ventajas?
- Es uno de los métodos más eficaces para el control de la natalidad.
- Es reversible. Se puede sacar del útero.
- Funciona por lo menos de 10 a 12 años.
- Previene embarazos extrauterinos.
- Es conveniente, seguro y privado.
- Lo pueden usar mujeres que no pueden usar píldoras con estrógeno.
- Lo puedes usar cuando estás dando el pecho.
- Te lo pueden colocar tan pronto has tenido un bebé o después de un aborto.
- Algunos estudios han encontrado que disminuye el riesgo de cáncer uterino.

¿Cuáles son las desventajas?
- Puedes tener calambres, dolores o manchado después de colocarlo. Puedes tener más calambres durante la menstruación.
- Puedes sangrar más días de lo normal. Si esto te molesta, consulta con la clínica. Pueden darte medicinas para aliviarlo.
- No te protege contra enfermedades de transmisión sexual. Siempre usa condones si estás en riesgo de contraer una de estas enfermedades.
- Un pequeño número de mujeres son alérgicas al cobre.
- Algunos hombres pueden sentir el cordón durante el acto sexual.
- Algunas mujeres que usan DIU tienen un mayor riesgo de sufrir enfermedad pélvica inflamatoria en el primer mes después de colocarlo.

Antes de salir de la clínica, usted debería ser capaz de sentir el hilo del dispositivo. Para hacer eso ponga un dedo en la vagina mientras esté sentada (acuclillada). Al tocar el cerviz, se sentirá como tocando la punta de la nariz con el hilo del dispositivo que sale del centro. Si Ud. siente el dispositivo, quiere decir que no está en lugar y debe ir a la clínica. Si Ud. no siente el hilo, es probable que Ud. no esté protegida. El DIU puede salirse sin que Ud. lo sepa.

¿Cuáles son las primeras señales de peligro con el DIU?
- Regla tarde, manchas o sangre anormal.
- Dolor de estómago o dolor durante el acto sexual.
- Exposición a las enfermedades de transmisión sexual (tal como las gonorrea y clamidia), derrame anormal
- No sentirse bien, calentura, escalofríos.
- No siente el hilo o el hilo está más largo o más corto.

¿Dónde puedo obtener un DIU?
Un médico, enfermera especialista, partera o departamento de salud pública lo puede colocar. No todos los profesionales médicos ofrecen este servicio. Llama a tu médico para saber si lo hace.

¿Qué pasa si tengo sexo y no uso anticonceptivos?
Llame a la oficina para conseguir Pastillas Anticonceptivas de Emergencia para prevenir el embarazo hasta 5 días después de que haya tenido sexo sin protegerse. También se puede visitar www.Not-2-Late.com para más información.
¿QUÉ ES EL DISPOSITIVO INTRAUTERINO (DIU) MIRENA o LILETTA (Levonorgestrel-LNg)?

Un DIU es un pequeño aparato que se coloca dentro del útero. El DIU Mirena o Liletta contiene una hormona llamada levonorgestrel. Esta hormona es una progestina muy parecida a la progesterona producida en los ovarios de la mujer cada ciclo menstrual. Cada semana, el DIU emite la misma cantidad de hormona que una mujer recibe cuando toma 1 o 2 mini-píldoras de progestina. La hormona en el DIU hace que el moco cervical se espese de modo que la esperma no pueda fertilizar el óvulo.

¿Cuáles son las ventajas del DIU Mirena o Liletta?
* Es uno de los métodos reversibles más eficaz creado hasta el momento.
* Evita embarazos ectópicos y la enfermedad inflamatoria pélvica.
* Disminuye los calambres menstrual.
* Disminuye los sangrados de la menstruación. Después de un año de uso, algunas mujeres no sangran.
* Se puede dejar en lugar por hasta cinco años, según la autorización de la FDA.
* Con el paso del tiempo, un DIU es seguro y barato.
* Una vez que se quita el DIU LNG, usted puede quedar embarazada.

¿Cuáles son las desventajas del DIU Mirena o Liletta?
* Puede cambiar el ciclo menstrual. En los primeros meses, pueden haber más días con sangrado. Después de 6-8 meses, pueden haber menos días con sangrado, y a veces su período puede detenerse por completo. El cambio en el patrón de sangrado podría molestarle. Si ésto sucede, llame a su médico. Hay medicamentos que pueden ayudarle a regular el patrón de sangrado.
* El DIU no le protege de enfermedades de transmisión sexual (ETS). Usted necesita usar condones para protegerse contra ETS.
* Algunas mujeres usando DIU tienen un mayor riesgo de sufrir enfermedad pélvica inflamatoria en el primer mes después de ser colocado el mismo.

Antes de salir de la clínica, y si se siente cómoda haciéndolo, le exhortamos a que palpe los hilos del dispositivo. Para hacer eso, ponga un dedo en la vagina mientras está sentada (acuclillada). Usted sentirá su cérvix, que es suave y redonda y se siente como la punta de su nariz, con los hilos del aparato saliendo del centro. Si usted siente el dispositivo, no está en su lugar correcto. Si usted no siente los hilos, usted podría no estar protegida. Utilice métodos secundarios de protección y venga a la clínica para que la veamos. El DIU puede salirse sin que usted lo sepa. No hale los hilos.

Signos y síntomas a verificar:

P - Período tardío (embarazo), manchado o sangrado fuera de lo normal
A - Dolor abdominal, dolor al tener coito
I - Exposición a infecciones (como Clamidia y Gonorrea), flujo fuera de lo normal
N - No sentirse bien, fiebre, escalofríos
S - Hilo perdido, más corto o largo

¿Dónde obtengo un DIU?
Usted puede obtener un DIU de su médico, enfermera especialista, partera, o departamento de salud. No todos los médico ofrecen este servicio, por lo que debe verificar con anticipación.

¿Qué pasa si tengo sexo y no uso anticonceptivos?
Llame a la oficina para conseguir Pastillas Anticonceptivas de Emergencia para prevenir el embarazo hasta 5 días después de que haya tenido sexo sin protegerse. También se puede visitar www.Not-2-Late.com para más información.
### 2.3 STERILIZATION:
Procedure for Submitting Request for Sterilization Funding – Public Health Offices

| The client qualifies if s/he… | • Is 21 years of age or older.  
| | • Does not have Medicaid/other insurance and is not eligible for Medicaid.  
| | • Is a Title X FP client with a Priority A rating for tubal ligations or Priority A or B for vasectomy.  
| His/her medical record includes… | • Documentation of either:  
| | o A Title X visit within the last 12 months that includes a comprehensive client health history and physical exam, as described in the FPP Protocol Section 1, Subsection 1.2.H.a “Contraceptive Services”, or  
| | o PHO clinician reviews the outside records that the client had a comprehensive visit described in the FPP Protocol Section 1, Subsection 1.2.H.a “Contraceptive Services” and documentation that the client is a suitable candidate for sterilization surgical procedure that may require general anesthesia.  
| | • An assessment of contraindication and, if present, documentation that a Surgical Provider was notified and agrees to perform the procedure.  
| | • Documentation of non-coercive sterilization counseling and education (STEP 3 of Section 1, Subsection 1.2.H.a and Section 2, Subsection 2.3.D below), including the permanent nature of sterilization and the alternative, most effective, reversible methods such as IUDs and implants.  
| | • Justification of Priority Level Rating (see FPP Protocol Sterilization section), for tubal ligation.  
| | • Clinician’s documentation of sterilization referral order.  
| Forms required include… | • Current Income Assessment Worksheet, completed, signed, and dated by client and staff.  
| | • Current Consent for FP Services form, signed and dated by client.  
| | • Current Sterilization Request/Consent for Sterilization forms, with all blank areas filled in.  
| | o Each form must be scanned and filed in the client’s MR.  
| Only after all the above criteria are met, mail the following documents to the FP State Office: | • The completed Sterilization Request Form.  
| | • The completed Consent for Sterilization Form.  
| When the PHO receives the approved request: | • The client is entered into the PHO internal tracking system (approved, not approved, pending);  
| | • The client is notified; and,  
| | • Arrangements are made for the client to pick up their approved paperwork.  
| During the appointment for paperwork pick-up, the PHO clerk will… | • Assist the client with making an appointment for their procedure.  
| | • Scan a copy of the approved paperwork into the medical record.  
| | • Give the client copies of:  
| | o Approved sterilization request,  
| | o Consent for sterilization,  
| | o Instruction letter,  
| | o Printed copies of the annual physical exam/health history  
| | o Other pertinent information.  
| | • Review with the client the consent’s expiration date, appointment date, clinic location/phone number, and next steps.  
| | • Enter the charge and collect the percentage pay, if due, from the client.  
| | • Inform the FP State Office of the client’s name and procedure appointment date.
## Sterilization Process for Non-PHOs to be used as a Reference

<table>
<thead>
<tr>
<th>Condition</th>
<th>Action</th>
</tr>
</thead>
</table>
| The client is 21 years of age or older? | • If yes, **PROCEED**.  
  • If no, **Stop**; the client does not qualify for FPP Title X sterilization funds. |
| Does client have private insurance? | • If no, **PROCEED**.  
  • If yes, **STOP**; the client does not qualify for FPP Title X sterilization funds.  
  Have the client contact their insurance company. |
| Does client have Medicaid (e.g., FP, Centennial Care MCOs)? | • If no, **PROCEED**.  
  • If yes, **STOP**; the client does not qualify for FPP Title X sterilization funds.  
  Have the client contact Medicaid.  
  Refer to any provider accepting Medicaid. |
| Is client eligible for FP Medicaid? | • Consider: Eligibility for FP Medicaid: NM Resident, U.S. Citizen/approved immigrant status, income up to 235% Fed Poverty level and a SS Number.  
  • If no, **PROCEED**.  
  • If yes, **STOP**; the client does not qualify for FPP Title X sterilization funds.  
  Refer to Income Support Division. |
| Contraindication | • If none, **PROCEED**.  
  • If contraindications are noted; consultation with the surgeon is required.  
  If you are also the provider who will perform the surgery, it would be helpful to send a referral that includes your acceptance to perform surgery despite the contraindication. |
| Priority Rating | • FPP is currently accepting applications for **Female Priority A only & Males Priority A or B**.  
  • If one of the criteria is met, **PROCEED**. **Refer the client to a Public Health Office** with a completed referral for FPP sterilization and copies of client's FP/annual exam medical record in the last 12 months, if available.  
  • If criteria are not met, the client does not qualify for FPP Title X sterilization funds. |
A. EQUIPMENT

- Diagrams of female/male pelvic anatomy.
- Educational materials on tubal ligation/vasectomy e.g., FPP-approved brochure or DVD.
- **Current** federal “Consent for Sterilization Form”
- “Family Planning Program Sterilization Request Form”
  ([https://nmhealth.org/publication/view/form/2087](https://nmhealth.org/publication/view/form/2087)).
- List of current medical providers available for referral (Appendix F).

B. INDICATIONS

There are limited funds available for uninsured FPP clients who are not eligible for Medicaid and choose a permanent method. Prior to submitting the application, PHN/PHD clinician will use the algorithm above to determine the client's eligibility.

PRIORITY RATING FOR STERILIZATIONS

**Priority A**

- Problems with birth control method (specify)
- High risk pregnancy (present or past) or risk of poor pregnancy outcome or significant health risk to the mother
- Genetic problems in the family
- History of physical abuse in the family
- Substance abuse (alcohol or other drugs)
- Inability to care for more children because:
  - Either of the parents have a severe medical condition
  - The family already had a child with a severe medical condition
- Multiparity (greater than or equal to 4 live births)

**Priority B**

- Unable to handle more children due to economics or unstable job situation
- Religious objections to other types of contraception

C. CONTRAINDICATIONS (for sterilization clients)

Clients with the following medical problems are generally NOT appropriate for outpatient surgery with **general** anesthesia:

- History of umbilical hernia repair with(out) mesh or large unrepaired umbilical hernia,
- Unstable angina or angina at rest,
- Symptomatic cardiac vascular disease,
- Symptomatic congenital heart disease (CHD),
- CHF requiring treatment in the ER or hospital admission within the last 3-6 months,
- Myocardial Infarction within the last 3 - 6 months,
- Morbid Obesity (BMI >45-50), a BMI over 45 can significantly increase anesthetic risk
- Sleep apnea where home CPAP is used or has been recommended,
- Pneumonia within the past 2-4 weeks,
- Acute intoxication (with drugs or alcohol) or active cocaine abuse,
- Serious, potentially life-threatening diseases that are not optimally managed (e.g., brittle diabetes, unstable angina, symptomatic asthma, uncontrolled hypertension).

The above criteria are only guidelines and the list is not exhaustive. Medical judgment is the final determinant. If you have a client that you are not sure meets eligibility for an outpatient procedure, contact the surgeon in advance. Document the details of consultation in the medical record.

D. COUNSELING & EDUCATION

1. Personnel working within the family planning project may be subject to prosecution if they coerce or try to coerce any person to undergo a sterilization procedure.
2. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services. This includes counseling on LARCs (IUDs, implant) as alternatives that are reversible and more
effective than sterilization. Clients who have chosen or are currently using an IUD or implant without complications are not an appropriate candidate for sterilization.

3. A PHN/clinician will provide sterilization counseling & education with the following objectives:

   a. To fulfill the federal requirements for voluntary/informed consent and to prevent possible postoperative regret in terms that are understandable, document the following discussion:

   - Sterilization procedure is considered to be irreversible;
   - Women and men < 30 yrs. old who undergo sterilization are at greater risk for regret;
   - Benefits, discomforts and risks of sterilization and possible effects of any anesthetic to be used (by using the educational materials listed in A. EQUIPMENT above);
   - The 30-day waiting period. Expiration is 180 days after signature. (Exact dates will be determined when the request is approved);
   - The client may withdraw consent at any time without affecting his/her right to future care/treatment and without loss/withdrawal of any federally funded program benefits; and
   - Co-pay is non-refundable (See also Appendix B: Special Circumstances).

   b. To discuss risk of pregnancy after sterilization.

   • Male sterilization is safer and more effective than female sterilization. The failure rate for vasectomy is 0.15% vs. 0.5% for tubal ligation.
   • For tubal ligation,

   **Age of Client:** Women ≤ 27 years old at the time of surgery have more failures;
   **Technique:** Failure rates for young women with some surgery techniques are as high as 5%, which is higher than or the same as LARCs/DMPA or even perfect use of OCPs.
   • When pregnancy occurs after sterilization, the likelihood of ectopic (tubal) pregnancy is quite high. **Abnormal vaginal bleeding, cramping, and abdominal pain after sterilization should be evaluated by a clinician to rule out ectopic pregnancy.**

   c. To ensure that the client/partner has interim contraceptive protection and any instructions needed to prevent pregnancy, either until the time of the procedure or after the vasectomy follow up tests have been completed. PHN: inform about ECP/clinician: offer future-use kit.

4. Clients sign statement on the Request form stating that they will "be responsible for related costs not previously approved" (e.g., x-rays, follow-up sperm counts, some special blood work, pathology requests during/after procedure or other lab costs), and any costs related to complications of this procedure.

5. Advise client that agreements between FPP and sterilization providers do not include tubal ligation procedures during C-sections or Essure® as it may affect coverage of procedure.

E. CONSENT/FORM: A PHN/clinician will assist the client with the completion of forms.

1. Consent for Sterilization Form (federal form):

   a. All areas are required for federal reporting.
   b. Use the list in Appendix F to **INDICATE WHICH PHYSICIAN OR GROUP PRACTICE WILL BE PERFORMING THE PROCEDURE.** This helps determine the correct charges, and allocation of budget. Explain to the client that a change in provider/surgeon must be approved by the Family Planning State Office.

2. The Family Planning Program Sterilization Request Form should be filled in completely and signed by the client. Comments should be concise and include priority rating justification.

F. POST PROCEDURE VISIT SCHEDULE

1. Clients may be seen 2 weeks post procedure (Not mandatory). At that time, document vital signs, the client's physical/psychosocial wellbeing, and other needs as warranted.
2. Female clients should be informed of the need for routine gynecological check-ups.
3. Clients should complete the “Evaluation of Referral Provider” form at this visit (if not already done) and send it to Family Planning State Office.
## FAMILY PLANNING PROGRAM STERILIZATION REQUEST FORM

### CLIENT INFORMATION

1. **Name (Last, First, Middle Initial):**
2. **Date of Birth:**
3. **Date Consent Signed:**
4. **Clinic Name:**

5. **Type of Procedure Requested:**
   - [ ] Tubal Ligation
   - [ ] Post Partum Tubal Ligation
   - [ ] Vasectomy

6. **Percent Pay (From current Federal Poverty Guidelines):**

7. **Staff Name and Phone #:**

8. **Priority Rating:**
   - [ ] Priority A
   - [ ] Priority B
   - [ ] Priority Justification:

9. **PHD Region:**

10. **Pay Source:**

   - Does client have private insurance? [ ] Yes [ ] No
   - If yes, STOP and have client contact their insurance company.
   - Does client have Medicaid (e.g., FP, Centennial Care MCOs)? [ ] Yes [ ] No
   - If yes, STOP and refer to any provider accepting Medicaid.
   - Is client eligible for FP Medicaid? [ ] Yes [ ] No
     (Eligibility for FP Medicaid: NM Resident, U.S. Citizen, approved immigrant status, income up to 235% Fed Poverty level and a Social Security Number).

11. **I authorize the release of any medical information necessary to process this claim.**
    
    I will be responsible for related cost not previously approved.

    **Autorizo la liberación de cualquier información de salud necesaria para procesar mi reclamación.**
    
    Me haré responsable de cualquier costo relacionado que no haya sido aprobado previamente.

**CLIENT SIGNATURE:**

### STATE FAMILY PLANNING OFFICE INFORMATION

12. **Control Number:**
13. **Consent Valid (30 days after signature):**
14. **Status of Request:**
    - Approved
    - Not Approved

15. **Consent Expiration (180 days after signature):**
16. **Approval Date:**
17. **Total Amount:**
18. **Date put on pending list:**

**PHYSICIAN INFORMATION (To be filled in by SURGEON):**

19. **Date Procedure/Service:**
   - Tubal Surgery
   - Facility
   - Anesthesiology
   - Vasectomy

   **Amount Approved by DEPT. of HEALTH:**

   - Provided By

   **$**

   **$**

   **$**

   **Approved By:**

   **PHD Staff**

20. **Accept assignment as per agreement with PHD Family Planning Program:**
    - [ ] YES [ ] NO

   DOH/PHD to remit payment for medical and/or other services indicated above.

21. **I certify that all services indicated were completed:**

   **Signature of Physician:**
   **Date:**

   **I certify that this is true copy of the original and that payment for services has not been received:**

   New Mexico Public Health Division – Family Planning—Sterilization Request Rev 8/18
2.4 **INJECTABLES or DEPOT MEDROXYPROGESTERONE ACETATE (DMPA)**

A. **EQUIPMENT**

- Client educational counseling handout
- Current calendar or pregnancy wheel
- Return visit reminder card
- DMPA 150mg/ml intramuscularly

B. **INDICATION**

DMPA is a reversible contraceptive injection that can be used by women of all ages (including teens), particularly if the client is willing to accept a change in her menstrual periods and able to tolerate injections.

C. **PRECAUTIONS AND CONTRAINDICATIONS**

Medical conditions categorized as 3 or 4 in U.S. MEC.

For Category 3, the clinician will document client counseling of risks/benefits and reasons that the benefits outweigh the risk in the client medical record; for Category 4, do not provide the method.

D. **HEALTH SCREENING/EXAM**

1. Within the past 12 months, client must have on record a complete medical history as described in Section 1, Subsection 1.2.H.a Contraceptive Services.

2. If the client is changing methods of contraception, provide tiered approach contraceptive counseling and review the medical history with the client for new information. Assess any changes in health status, including medications.

3. Identify and record any allergies particularly to DMPA.

4. Obtain baseline BP, weight/height and BMI measurement as they are helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with DMPA.

E. **COUNSELING & EDUCATION**

The client counseling handout can serve as the basic format for client education.

1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services.

2. **Efficacy:** With typical use, approximately 6 out of 100 women will become pregnant in the first year of use of DMPA. With perfect use, only 2 women in 1,000 will get pregnant in one year.

3. **Risks/Benefits:** Document discussion of DMPA risks/benefits and client understanding in the client’s record.
   - DMPA does not have estrogen-related side effects of COCs. It is convenient for women who have trouble taking oral contraceptives on a regular daily basis or using a coitus-related method since it is injected intramuscularly at 11 to 13-week intervals. DMPA works by preventing follicular maturation and ovulation.
   - **Common side effects:**
     - Potential changes in bleeding patterns. Amenorrhea and unscheduled spotting or light
bleeding is common, and heavy or prolonged bleeding can occur. These bleeding irregularities are generally not harmful and might decrease with continued DMPA use.

- Delayed fertility (lasting 6-12 months) after injections are stopped, and possible undesired hormonal effects such as depression, decreased libido, headaches, dizziness, weight gain, decreased glucose tolerance, decreased high-density lipoprotein levels, or decreased bone density.
- Educate clients on the importance of adequate calcium intake, moderate weight bearing exercise, and not smoking to prevent osteoporosis.
- According to WHO, “since the effect of DMPA on bone mineral density is largely reversible, any lifetime increase in fracture risk is likely to be small.” However, women with conditions that place them at high risk for osteoporosis, and fracture, such as chronic corticosteroid use, disorders of bone metabolism, a strong family history of osteoporosis (that may represent a genetic mutation associated with fracture), or anorexia nervosa – may not be well suited for long-term DMPA use.


4. **Warning Signs:** Ascertan that the client has information about danger signs by counseling and providing the DMPA client counseling handout.

5. Caution all women about STIs and encourage condom use if not in a monogamous relationship.

6. ECP information in the case that the client is > 2 weeks late for a scheduled repeat injection and had unprotected sexual intercourse.

F. **CONSENT:** Although Title X does not require a method-specific consent form for DMPA, nurse/clinician must document the client’s recall and understanding of the counseling (based on the teach-back method) in the medical record.

G. **PRESCRIPTION**

There are two circumstances for providing DMPA.

1. A PHN may give the first DMPA injection at 150mg IM to a new FP client by using the Quickstart Standing Order to check client’s eligibility.

2. CNP/CNM/PA or Physician must prescribe the method. They may prescribe “DMPA 150mg IM now and every 11 to 13 weeks for a total of 12 months.” The nurse may administer the DMPA to an established client under a clinician’s valid order.

The clinician may also order ECP for future use at this time.

H. **PROCEDURE**

1. **Initiation Timing:** The first DMPA injection can be given at any time if the nurse/clinician is reasonably certain that the client is not pregnant.

2. DMPA vial or prefilled syringe must be shaken vigorously for at least 1 minute before the injection. The uniform suspension is to be administered with aseptic technique as a deep intramuscular injection in the deltoid or gluteal area (either site may be used at the nurse’s discretion). Injection is not usually painful.
   - **DO NOT RUB/MASSAGE THE INJECTION SITE** because this may reduce the drug effectiveness. Instruct the client not to rub/massage the site.
   - Note the site and date of the administration and lot # of the drug in the client record. Record client’s information and lot # in pharmacy log.

3. **Need for Back-Up Contraception:**
   - If DMPA is started within the first 7 days since menstrual bleeding started, no additional contraceptive protection is needed.
   - If DMPA is started >7 days since menstrual bleeding started, the client needs to abstain
from sexual intercourse or use additional contraceptive protection for the next 7 days.

4. Switching from another contraceptive method to DMPA:
   • Switching from an IUD: If the woman has had sexual intercourse since the start of her current menstrual cycle and it has been >5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A health care provider may consider any of the following options:
     o Advise the women to retain the IUD for at least 7 days after the injection and return for IUD removal.
     o Advise the woman to abstain from sexual intercourse or use barrier contraception for 7 days before removing the IUD and switching to the new method.
     o If the woman cannot return for IUD removal and has not abstained from sexual intercourse or used barrier contraception for 7 days, advise the woman to use ECPs (with the exception of UPA) at the time of IUD removal.

5. Institute a reminder system for a client that may consist of a return visit reminder card. It is the client's responsibility to show up as arranged for repeat injections or reschedule an appointment as needed. No follow-up on no-shows is expected of nursing staff.

I. VISIT SCHEDULE FOR METHOD

Clinicians may prescribe the initial order for DMPA in two ways:
As ordered/prescribed by a clinician, the nurse will provide repeat DMPA injections every 3 months (11-13 weeks) for clients who do not have clinical concerns. The nurse will consult a clinician if the client wants DMPA before or after this 11 to 13 week window.

Clinicians may also choose to write on the initial prescribing order that DMPA may be given up to 2 weeks late (15 weeks from the last injection) for clients who do not have clinical concerns without requiring a call to the clinician or additional contraceptive protection.

For clients late for reinjection interval: If a client presents after the 15th week from the last injection, the nurse will consult a clinician if the client wants to continue DMPA after this 2 week window.

Repeat DMPA injection visits should be recorded with attention to spotting, irregular bleeding, heavy bleeding, missed periods, pain at injection site from previous injections, breast tenderness or breast lump, depression or major mood changes, decreased libido, repeated/very severe headaches, severe lower abdominal pain, nausea/vomiting, pregnancy concern, or weight gain of >5% of their baseline body weight. For PHOs, weight can be monitored utilizing the flow sheet function in the PHD BEHR record.

Return for annual visit: when order expires, for additional prescription from clinician.

Clients who call/present with DMPA problems including weight gain of >5% of their baseline body weight will be referred to the clinician. If no clinician is available and the nurse assesses the problem as severe, the client should be referred to a private physician or the Emergency Room.

Before administering second DMPA dose take a good history to rule out pregnancy. Only about 1/3 of women will experience amenorrhea at 3 months after first DMPA injection. Therefore, before administering second DMPA injection to clients with amenorrhea, a nurse will consult a clinician to rule out pregnancy and perform a pregnancy test.

J. PROBLEM MANAGEMENT (FOR CLINICIANS)

Early Injection: According to U.S. SPR, there are no time limits on early injections; the repeat injection can be given when necessary (e.g., when a client cannot return at the routine interval).

Late Injection:
• The repeat DMPA injection can be given up to 2 weeks late (15 weeks from the last injection) without requiring additional contraceptive protection.
• If the client is >2 weeks late (>15 weeks from the last injection) for a repeat DMPA injection, the client can have the injection if the clinician is reasonably certain that she is not pregnant. She needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days. Clinician might consider ordering/prescribing ECP if appropriate. **Note: UPA should not be prescribed.**

**Weight Gain:** A systematic review identified a limited body of evidence that examined whether weight gain in the first few months after DMPA initiation predicted future weight gain.

- Two studies found significant differences in weight gain/BMI at follow-up periods ranging from 12 to 36 mos. between early weight gainers (i.e., those who gained >5% of their baseline body weight within 6 mos. after initiation) and those who were not early weight gainers. The differences between groups were more pronounced at 18, 24, and 36 mos. than at 12 mos.
- One study found that most adolescent DMPA users who had gained >5% of their baseline weight by 3 mos. gained even more weight by 12 mos.

**K. PREGNANCY OCCURRENCES**

As a quality assurance measure, FPP tracks unexplained pregnancies that occur while the client is using DMPA/Nexplanon/LNg IUD, to determine efficacy or defect of the method. If a nurse/clinician determines that a pregnancy occurred on one of these methods without any other identifiable cause (e.g., missed/late insertion/injection, no back up birth control method, etc.) they should complete the “Pregnancy Occurrences Report” found following this section, and send it to the Family Planning Program by fax or secure email to the FPP Medical Director. In addition, inform the RHO.
Part I: Client Demographics

Initials: ___________  MRN#________________  Clinic Site:_______________________________________ Clinic Phone:_____________________________

Contraceptive Method______________________________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Part II: Clinical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date (month/day/year) of insertion or injection(s)</td>
</tr>
<tr>
<td>Lot #</td>
</tr>
<tr>
<td>LNMP and PMP</td>
</tr>
<tr>
<td>Reported bleeding pattern since method initiation</td>
</tr>
<tr>
<td>Medication history: TB drugs, antibiotics, anticonvulsants? (note dates)</td>
</tr>
<tr>
<td>If pregnancy test was done, give date(s) and results</td>
</tr>
<tr>
<td>EDC and how determined</td>
</tr>
<tr>
<td>Additional Comments:</td>
</tr>
</tbody>
</table>

Signature of person completing form __________________________________________________________________________ Title ____________________________ Date ____________________________

DOH/PHD/FHB/Family Planning- Rev. 04/17
DMPA SHOT
COUNSELING HANDOUT

What is DMPA?
DMPA is a birth control shot that you get once every 3 months. It is the hormone
Depot-Medroxy Progesterone Acetate (DMPA) and contains no estrogen.
You can get it in your arm or hip muscle.

How does it work?
It stops the ovary from releasing an egg. It thickens cervical mucus so sperm can't enter the uterus.
It also thins the lining of the uterus.

How effective is it?
DMPA is very effective. If the shot is on time only 2 women in 1,000 will get pregnant in one year.

When do I get the shot?
The first shot is given in the first 5 days of a normal period.

What are the advantages?
• Because you may bleed less, there may be less risk of anemia.
• There is also less menstrual cramping, endometrial cancer, ectopic pregnancy, pelvic inflammatory disease
(PID), ovarian cysts, fibroids, benign breast lumps and sickle–cell disease crises.
• You don’t have to worry about taking birth control daily.

What are the disadvantages?
• You may have irregular bleeding, spotting, or stop your period altogether. (The changes are safe and
expected.)
• A few women have heavy bleeding. (See your doctor or nurse if the bleeding bothers you. There is medicine
that can help.)
• It may be several months before your periods return to normal after your last shot.
• You are not protected against HIV or STIs. Use condoms if you are at risk.
• It may take 6-12 months and sometimes longer to get pregnant after the last shot.
• You might have an increase in appetite. Weight gain (3-5 lbs/year) occurs in many women.
• It causes calcium loss from bones. When DMPA is stopped, the calcium in bones begins to come back.

Warning Signs!
See your doctor or nurse if you have these or any other signs or concerns: Repeated, very painful headaches,
heavy bleeding, depression, or severe abdominal pain, pus, continued pain or bleeding at injection site.

Other Important Recommendations:
• Since you may gain weight, watch your calories and get lots of exercise.
• If you smoke, consider stopping. Smoking causes bone loss and so does DMPA.
• Follow these steps for bone health:
  o Do weight bearing exercise: walk, jog, and/or lift weights several days a week.
  o Take calcium. Teens should take 1300 mg a day. Adult women should take 1000 mg a day.
  o Eat calcium rich foods. 1 cup of milk, 1 ½ ounce of cheese and 1 cup of yogurt all have 300 mg of calcium.
  o Take calcium pills or calcium candy chews or Tums if there is not enough calcium in your diet.

If you are late for a shot: Use another method like spermicide and condoms. If you did not use birth control,
visit www.Not-2-Late.com for more information.
LA INYECCIÓN DE DMPA

¿Qué es la DMPA?
Es una inyección anticonceptiva que te dan cada tres meses. La DMPA se compone de acetato de medroxiprogesterona, una forma sintética de la hormona progesterona. No contiene estrógeno. La puedes recibir en el brazo o en la cadera.

¿Cómo funciona?
Impide que haya ovulación. Hace que el moco cervical sea más espeso y, por lo tanto, que el esperma no pueda entrar en el útero. También hace que el revestimiento del útero se vuelva más delgado.

¿Cuál es su eficacia?
La DMPA es muy eficaz. Si la inyección se da a tiempo, sólo 2 de cada 1000 mujeres quedarán embarazadas en un año.

¿Cuándo debo recibir la inyección?
La primera inyección debe darse en los primeros 5 días de una menstruación normal.

¿Cuáles son las ventajas?
• Menos riesgo de anemia, ya que el flujo menstrual es menor.
• También hay un menor riesgo de padecer calambres, cáncer de endometrio, embarazo extrauterino, enfermedad inflamatoria pélvica, quistes ováricos, fibromas, quistes en los pechos o anemia de células falciformes.
• No te tienes que preocupar diariamente por un método anticonceptivo.

¿Cuáles son las desventajas?
• Puedes tener menstruaciones irregulares, manchas o, tal vez, no tengas tu menstruación (estos cambios son de esperar y no son peligrosos).
• Algunas mujeres pueden tener mucho sangrado durante su menstruación. Si esto te molesta, díselo a tu médico. Hay medicamentos que te pueden ayudar.
• Después de dejar las inyecciones, pueden pasar varios meses sin que te baje la menstruación.
• No te protege contra el VIH u otras enfermedades de transmisión sexual. Si estás en riesgo de contraer cualquiera de éstas, usa condones.
• Puede tomar de 6 a 12 meses, a veces más, después de la última inyección, para quedar embarazada.
• Te puede aumentar el apetito y puedes aumentar de peso (3 a 5 lbs. por año) ocurre en muchas mujeres.
• Provoca pérdida de calcio en los huesos. Cuando las inyecciones de DMPA se dejan de poner, el calcio en los huesos comienza a regresar.

¡Señas de advertencia!
Consulta con un médico o una enfermera si tienes algunos de estos síntomas: Repetidos y fuertes dolores de cabeza, menstruación con sangrado abundante, depresión, dolor grave en el abdomen o si en el lugar de la inyección tienes pus, dolor o sangrado continuo. También consulta con un médico o una enfermera en caso de que haya otras cosas que te preocupen.

Otras recomendaciones importantes:
• Si fumas, considera dejar el hábito. El fumar puede causar pérdida de masa ósea, igual que la DMPA.
• La DMPA no protege contra el VIH y otras enfermedades de transmisión sexual.
• Sigue estos consejos para tener huesos saludables:
  o Haz ejercicios con pesas: camina, corre o levanta pesas varias veces a la semana.
  o Toma calcio. Las adolescentes deben tomar 1300 mg al día. Las mujeres adultas deben tomar 1000 mg diarios.
  o Come alimentos ricos en calcio. Una taza de leche, una onza y media de queso o una taza de yogur tienen cada una 300 mg de calcio.
  o Toma un suplemento de calcio ya sea en forma de pastillas, dulces o Tums si no consumes suficiente calcio en tus comidas.

Si recibiste la inyección más tarde lo debido o si se te pasó: Usa otro método, como condón y espermicidas. Si tienes relaciones sexuales sin protección, puedes tomar píldoras anticonceptivas de emergencia hasta 5 días después de haber tenido relaciones sexuales. Si no utiliza el control de la natalidad, visite www.Not-2-Late.com para más información.
2.5 VAGINAL CONTRACEPTIVE RING

A. EQUIPMENT

- Client counseling handout
- Calendar
- Contraceptive Ring sample (if available) for demonstration

B. INDICATION

The contraceptive ring is a reversible, combined hormonal method (containing a progestin, etonogestrel and an estrogen, ethinyl estradiol) that can be used by women of all ages who are not hesitant about touching their genitalia or who have no difficulty inserting or removing the ring.

C. PRECAUTIONS AND CONTRAINDICATIONS

Medical conditions categorized as 3 or 4 in U.S. MEC.

For Category 3, the clinician will document client counseling of risks/benefits and reasons that the benefits outweigh the risk in the client medical record; for Category 4, do not provide the method. For example, the usage of ring in women ≥ 35 years old who smoke <15 cigarettes/day is MEC 3 and ≥15 cigarettes/day is MEC 4.

Women who have pronounced pelvic relaxation or genital prolapse (such as multiparous women) may have difficulty using the ring.

D. HEALTH SCREENING/EXAM

1. Within the past 12 months, client must have on record a complete medical history as described in Section 1, Subsection 1.2.H.a Contraceptive Services.

2. If the client is changing methods of contraception, provide contraceptive counseling and review the medical history with the client for new information. Assess any changes in health status, including medications.

3. Identify and record any allergies particularly to estrogen/progestin.

4. Obtain baseline BP, weight/height and BMI measurement as they are helpful for monitoring over time.

E. COUNSELING & EDUCATION

The client counseling handout can serve as the basic format for client education.

1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services.

2. Efficacy: With typical use, approximately 9 out of 100 women will become pregnant in the first year of use of ring. With perfect use, only 3 women in 1,000 will get pregnant in one year.


   - The flexible ring is 2 inches in diameter and 1/8 inch in thickness. It is made of ethylene vinyl acetate polymer and is latex free. Ring can be stored for up to 4 months at room temperature. It releases hormones at steady and low dose rate so serum hormone levels do not fluctuate. It is left in the vagina for 3 weeks and then removed for 1 week to allow the woman’s menstrual period to occur during the ring-free week.
     - If the ring is left in place >3 weeks, she will still be protected up to 28 days. Instruct her
to remove it and insert a new ring after a one week ring-free break if desired.

- Extended use of combined hormonal contraceptives has been used to avoid estrogen-withdrawal side effects or to avoid bleeding in women who prefer amenorrhea. See Contraceptive Technology Dosing Regimens for further information.
- If the ring is left in place >28 days, she may not be protected. Rule out pregnancy. If negative, start using a back-up method until a new ring has been in place for 7 days.

- Avoid douching with the ring in place.
- After removal, the ring should be disposed of in the re-closable foil pouch in a waste receptacle.
- Ring removal during intercourse is not recommended; however, women who want to remove it during intercourse due to pressure or discomfort may do so without having to use a backup method as long as it is not removed for longer than 3 hours.
- After one ring-free week, a new ring is inserted.
- If ring falls out, it can be washed with soap in cool to lukewarm water and reinserted.
- If ring becomes disconnected at the weld joint, discard and replace it with a new ring.

4. **Side effects:** increased vaginal discharge, vaginal discomfort/irritation/infections, headache, nausea and weight gain. Advise to call as soon as a problem appears and not to discontinue the ring before consulting a nurse unless there are life-threatening symptoms below.

5. **Warning Signs:** Ascertain that the client has information about danger signs ACHES; see vaginal ring client counseling handout.

6. Caution all women about:
   a. STIs and encourage condom use if not in a monogamous relationship.
   b. Age and cigarette smoking-related risks. Offer self-help and referrals to smokers.

7. **CONSENT:** Although Title X does not require a method-specific consent form for vaginal ring, nurse/clinician must document the client’s recall and understanding of the counseling (based on the teach-back method) in the medical record.

8. **PRESCRIPTION**
   1. CNP/CNM/PA or Physician must prescribe the method. They may prescribe approximately a one year supply of rings. The client must return every 3 months for a refill because rings come in boxes of 3 and expire four months after dispensing.

   The Clinician may also order ECP for future use at this time.

   2. A PHN may dispense the rings to an established FPP client under a PHD clinician’s valid order.

   3. **Initiation Timing:** Ring can be initiated at any time if the clinician is reasonably certain that the woman is not pregnant. For Special Considerations for Initiation of Combined Hormonal Contraceptives (CHCs) including ring, a clinician may refer to U.S. SPR.

   4. **Need for Back-Up Contraception:**
      - If ring is started within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
      - If ring is started >5 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection (foam/film and condoms) for the next 7 days.
      - If there is any concern about possible pregnancy, wait until the first day of her next menses and start on that day. No back-up is necessary.

   5. For switching from COC, wait until next regular menses. Insert ring first day of bleeding.
H. VISIT SCHEDULE FOR METHOD

1. Initial visit: Dispense 1 box (contains 3 rings for 3 cycles/months). When dispensing rings to the client, enter the expiration date on the label. The date should not exceed either 4 months from the dispensing date or the expiration date, whichever comes first.

2. Return visits: Every 3 months for a resupply. Dispense 1 box per visit following the clinician’s order and label the box as instructed above. Return for annual visit when order expires, for additional prescription from clinician.

3. Chart should include updated health history with particular attention to the last normal menstrual period, cigarette smoking, weight, blood pressure, and ACHES symptoms. Ask about difficulty during removal or insertion or frequent expulsion. Women may need closer follow-up if they have genital prolapse, severe constipation, or frequent vaginal infection (i.e., recurrent yeast infection).

   Clinician will document problems that were addressed.

I. PROBLEM MANAGEMENT (FOR CLINICIANS)

Clients who call or present with problems with the ring will be referred to a clinician. If no clinician is available and the nurse assesses the problem as severe, the client should be referred to a private physician or the Emergency Room.

Delayed Insertion or Reinsertion of Vaginal Ring

U.S. SPR Figure 4: Recommended Actions after Delayed Insertion or Reinsertion with Vaginal Ring
How do I use the vaginal ring?

How do I insert the vaginal ring?
- First wash your hands and open the foil pouch that it comes in.
- Choose the most comfortable position: standing with one leg up, squatting or lying down.
- Squeeze the ring with your fingers to make it long and narrow.
- While holding the ring, gently insert the ring into your vagina as far as it will go. The ring does not need an exact position to work.
- If the ring falls out, rinse with water and put it back in.

How long do I have to leave it in?
Leave the ring in place for 3 weeks in a row.
Do not remove the ring for intercourse.
If you want to remove it because it is not comfortable during intercourse, you may do that without having to use a back-up method, but remember never remove it for more than three hours or you will not be protected.

How do I remove the ring?
- After 3 weeks in a row; remove the vaginal ring on the same day of the week you put it in.
- To remove, hook index finger under the rim or take hold of it with index and middle fingers, then pull it out.
- Put the used ring in its original foil pouch. Throw it in the trash, out of the reach of children and pets (do not flush it down the toilet).

When do I put a new vaginal ring in?
After 3 full weeks (21 days), you remove the vaginal ring.
Wait 7 days before you put a new one in. This is your 7-day break with no ring. Your menstrual period will usually start 2 to 3 days after you removed the ring.
After this 7-day break, insert a new vaginal ring; even if you have not finished your menstrual period.

Example: The calendar shows an example for a complete cycle (one cycle means 3 weeks on and 1 week off).

What do I need to remember about the vaginal ring?
- The ring has to be left in your vagina for 3 weeks (21 days) in a row.
- If the ring is out of your vagina more than 3 hours, put it back in. You are not protected: use another birth control method (like condoms) or do not have sex for the next 7 days.
- If you had unprotected intercourse (because the ring was out more than 3 hours), use emergency contraception (morning after pill).
- If you use tampons, vaginal medications, oral antibiotics and spermicides, the ring still works.

WARNING SIGNS: “ACHES”: Go to the Emergency Room if these symptoms develop:

A Abdominal pain. Severe pain could be a blood clot in pelvis or liver, benign liver tumor or gallbladder disease.
C Chest pain or shortness of breath. This could be blood clot in lungs, heart attack, angina (heart pain), or breast lump.
H Headaches. Severe headaches could be a stroke, migraine headache with nerve/brain signs (blurred vision, spots, zigzag lines, weakness, difficulty speaking), other headaches caused by pills, or high blood pressure.
E Eye Problems. Loss of vision, blurred, or double vision could be a stroke, migraine headache with nerve/brain problems (blurred vision, spots, zigzag line), or blood clots in eyes.
S Severe leg pain could be: inflammation and blood clots of a vein in the leg

If at any time headaches clearly get worse or abnormal nerve/brain symptoms occur, stop using the ring immediately!

Emergency Contraception (ECPs) If you had sex and did not use contraception, call the clinic for ECPs to prevent pregnancy up to 5 days after unprotected sex. You can also visit www.Not-2-Late.com for more information.
¿Cómo se usa el anillo vaginal?

¿Cómo coloco el anillo vaginal correctamente?
- Primero lávese las manos y abra el sobre donde viene un anillo.
- Para introducirllo, elija la posición que le sea más cómoda para usted, por ejemplo, de pie con una pierna levantada, en cucullillas o acostada.
- Presione los lados del anillo para estrecharlo.
- Mientras sujetá el anillo, empújelo hacia adentro con su dedo lo más que pueda. El anillo no necesita una posición especial para que funcione.
- Si el anillo se sale en algún momento, lávelo con agua y vuelva a ponerlo en su lugar.

¿Por cuánto tiempo lo dejo puesto?
Deje el anillo colocado por tres semanas en forma continua.
No se quite el anillo para tener relaciones sexuales. Si al tener relaciones le molesta, puede quitárselo sin tener que usar otro método anticonceptivo, pero recuerde no se lo quite por más de tres horas.

¿Cómo se quita el anillo vaginal?
- Después de tres semanas, debe retirar el anillo vaginal.
- Para retirarlo puede agarrarlo por bajo con su dedo en forma de gancho o lo puede agarrar con su dedo índice y el de en medio, y después tirar de él hacia fuera.
- Ponga el anillo usado en su sobre original y tírelo a la basura fuera del alcance niños y mascotas (nunca lo tire al excusado).

¿Qué es el periodo de descanso?
Después de llevar el anillo 3 semanas (21 días) en forma continua, debe retirarlo.
Entonces espere siete días antes de colocar un nuevo anillo. Estos siete días son el periodo de descanso y es cuando su menstruación va a comenzar, posiblemente como dos o tres días después de haber retirado el anillo.
Después de estos siete días de descanso, introduzca un nuevo anillo vaginal, incluso si su menstruación todavía continua.
Este es un ejemplo de un ciclo completo: tres semanas con anillo y una semana sin él.

¿Qué es importante que recuerde sobre el anillo vaginal?
- El anillo debe permanecer en la vagina por un periodo de tres semanas (21 días) en forma continua.
- Si en algún momento el anillo se sale y está afuera más de tres horas, vuelva a colocarlo. Atención: necesitará usar otro método como condones o no tener relaciones sexuales durante siete días.
- Si el anillo estuvo fuera más de tres horas y no usó ningún método anticonceptivo, use la anticoncepción de emergencia (píldora del día siguiente).
- Si usa tampones, medicinas vaginales, antibióticos o espermicidas, el anillo sigue siendo igual de eficaz.

Problemas graves
Dolor abdominal – dolor grave en el área del estómago o sensibilidad (dolor al tocar) esta área.
Ojos – problemas de la vista como visión borrosa, visión doble o ceguera.
Le duelen las piernas – si alguna de sus piernas o pantorrillas está hinchada o le duele.
Opresión en el pecho – siente un dolor opresivo o agudo en el pecho o sensación de presión en el pecho; tose sangre o le falta el aire al respirar.
Repentinamente dolores de cabeza – Dolores de cabeza graves o repentinos, vómitos, mareos o desmayos.
No puede encontrar una respuesta a los síntomas que describe, llame a la oficina para conseguir Pastillas Anticonceptivas de Emergencia para prevenir el embarazo hasta 5 días después de que haya tenido sexo sin protegerse. También se puede visitar www.Not-2-Late.com para más información.
2.6 COMBINED ORAL CONTRACEPTIVE PILLS

A. EQUIPMENT

- Client counseling handout
- How to start taking birth control pills counseling handout
- What happens if you miss your birth control pills counseling handout
- Calendar
- Combined oral contraceptives pills (COCs)

B. INDICATION

COC is a reversible, combined hormonal method containing a progestin and an estrogen, ethinyl estradiol-EE that can be used by women of all ages. FPP provides different types of COCs. Clinic staff may familiarize themselves with oral contraceptive pills (OCPs) by reviewing “The Basics of Oral Contraceptives” training slides at https://nmhealth.org/publication/view/training/2053/. For detailed information in selecting an appropriate OCP type for a client, refer to Contraceptive Technology textbook.

C. PRECAUTIONS AND CONTRAINDICATIONS

Medical conditions categorized as 3 or 4 in U.S. MEC.

For Category 3, the clinician will document client counseling of risks/benefits and reasons that the benefits outweigh the risk in the client medical record; for Category 4, do not provide the method. For example, the usage of COCs in women ≥ 35 years old who smoke <15 cigarettes/day is MEC 3 and ≥15 cigarettes/day is MEC 4.

D. HEALTH SCREENING/EXAM

1. Within the past 12 months, client must have on record a complete medical history as described in Section 1, Subsection 1.2.H.a Contraceptive Services.

2. If the client is changing methods of contraception, provide shared-decision making contraceptive counseling and review the medical history with the client for new information. Assess any changes in health status, including medications.

3. Identify and record any allergies particularly to estrogen/progestin.

4. Obtain baseline BP, weight/height and BMI measurement as they are helpful for monitoring over time.

E. COUNSELING & EDUCATION

The client counseling handout can serve as the basic format for client education.

1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services.

2. **Efficacy:** With typical use, approximately 9 out of 100 women will become pregnant in the first year of use of COCs. With perfect use, only 3 women in 1,000 will get pregnant in one year.

3. **Correct use/Risks/Benefits:** Document counseling and client’s understanding in the record. Instructions for OCP use and instructions for missed pills are at the end of this section.
WHEN TO START ORAL CONTRACEPTIVES AND THE NEED FOR BACK-UP METHOD
(counseling handout may be used.)

- If pregnancy has been ruled out, she may start on the day of her visit. If uncertain whether the client might be pregnant, the benefits of starting COCs likely exceed any risk; therefore, starting COCs should be considered at any time with a follow-up pregnancy test in 2-4 weeks.
- After Plan B ECP, take regular COC 12 hours afterwards, or wait until first day of next period.
- After ulipristal acetate (UPA) ECP, start COC no sooner than 5 days after use of UPA.
- Instruct the woman to use foam/film and condoms during the first 7 days of pills.

4. Missed pills education: For U.S. SPR recommended missed pill instructions, please see Problem Management for additional clinician guidance.

5. Side effects: breakthrough bleeding and/or spotting, breast discomfort, headache, nausea/vomiting (especially in the first few cycles) and mood changes. Side effects tend to be mild and transient. Advise to call as soon as a problem appears, not to discontinue the pills before consulting a nurse unless there are life-threatening symptoms below.

6. Warning Signs: Ascertain that the client has information about danger signs ACHES; see birth control pills client counseling handout.

7. Caution women about:
   a. STIs and encourage condom use if not in a monogamous relationship.
   b. Age and cigarette smoking-related risks. Offer self-help and referrals to smokers.

8. ECP information in the case that the client had sexual intercourse and she has missed too many COC pills (please see U.S. SPR Recommended Actions After Late or Missed Combined Oral Contraceptives, below).

F. CONSENT: Although Title X does not require a method-specific consent form for COCs, nurse/clinician must document the client’s recall and understanding of the counseling (based on the teach-back method) in the medical record.

G. PRESCRIPTION

1. CNP/CNM/PA or Physician must prescribe the method. They may prescribe up to a 12-month supply of COCs; 13 cycles of 28-day pill packs are needed for 12 months. A PHN may dispense the OCPs to an established FPP client under a PHD clinician’s valid order.

   The Clinician may also order ECP for future use at this time.

2. A PHN may give the first 3 cycles of OCPs to a FP client by using the Quickstart Standing Order to check client’s eligibility.

3. Initiation Timing: OCPs can be initiated at any time if the clinician is reasonably certain that the woman is not pregnant. For Special Considerations for Initiation of Combined Hormonal Contraceptives (CHCs) including OCPs, a clinician may refer to U.S. SPR.

4. Need for Back-Up Contraception:
   - If OCPs are started within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
   - If OCPs are started >5 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection (foam/film and condoms) for the next 7 days.
• If there is any question about possible pregnancy, wait until the first day of her next menses and start on that day. No back-up is necessary.

H. VISIT SCHEDULE FOR METHOD

1. For clients who have never taken pills before, the pill supply shall be managed as follows:
   • Initial visit: 3 cycles - return for renewal during 3rd package
   • Return visit: 10 cycles - return for annual visit during last package.

   Pill supply for routine return clients should be managed as follows:
   Annual visit for prescription: 13 cycles (packs) - return for the next annual visit before the last pack.

2. The nurse may make exceptions to the above visit when there are problems or with available COC supply or when a client needs to be monitored more closely (for example, teens). Document justification for the exception.

3. FPP supplies OCPs by class (see OCP Substitute Table in Section 3). If a clinic does not have the brand the client is taking, the nurse can dispense another brand within the same class. Document in the medical record that the brand of pills is changed and document the new brand. If there is a need to switch the class of OCP, the nurse will need a clinician order.

4. Chart should include updated health history with particular attention to the last normal menstrual period, cigarette smoking, weight, blood pressure, and ACHES symptoms. Ask about difficulty using the pills.

   Clinician will document problems that were addressed.

I. PROBLEM MANAGEMENT (FOR CLINICIANS)

Clients who call or present with problems with the pills will be referred to a clinician. If no clinician is available and the nurse assesses the problem as severe, the client should be referred to a private physician or the Emergency Room.

Recommended Actions After Late or Missed Combined Oral Contraceptives (U.S. SPR)
When using the following algorithm for late of missed doses of combined oral contraceptives, SPR states that a dose is considered late when <24 hours have elapsed since the dose should have been taken. A dose is considered missed if ≥24 hours have elapsed since the dose should have been taken.

For example, if a COC pill was supposed to have been taken on Monday at 9:00 a.m. and is taken at 11:00 a.m., the pill is late; however, by Tuesday morning at 11:00 a.m., Monday’s 9:00 a.m. pill has been missed and Tuesday’s 9:00 a.m. pill is late. For COCs, the recommendations only apply to late or missed hormonally active pills and not to placebo pills. Separate algorithms for missed patch/ring are included in those sections of the protocol.

The SPR algorithm for late and missed pills follows this section.

https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/combined.html
### Recommended Actions After Late or Missed Combined Oral Contraceptives

**If one hormonal pill is late: (<24 hours since a pill should have been taken)**
- Take the late or missed pill as soon as possible.
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- No additional contraceptive protection is needed.
- Emergency contraception is not usually needed but can be considered (with the exception of UPA) if hormonal pills were missed earlier in the cycle or in the last week of the previous cycle.

**If one hormonal pill has been missed: (24 to <48 hours since a pill should have been taken)**
- Take the most recent missed pill as soon as possible (any other missed pills should be discarded).
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills have been taken for 7 consecutive days.
- If pills were missed in the last week of hormonal pills (e.g., days 15-21 for 28-day pill packs):
  - Omit the hormone-free interval by finishing the hormonal pills in the current pack and starting a new pack the next day.
  - If unable to start a new pack immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills from a new pack have been taken for 7 consecutive days.
- Emergency contraception should be considered (with the exception of UPA) if hormonal pills were missed during the first week and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered (with the exception of UPA) at other times as appropriate.

**If two or more consecutive hormonal pills have been missed: (≥48 hours since a pill should have been taken)**

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**Abbreviation:** UPA = ulipristal acetate

**Source:** For full recommendations and updates, see the U.S. Selected Practice Recommendations for Contraceptive Use webpage at [http://www.cdc.gov/reproductivehealth/unintendedpregnancy/ussspr.htm](http://www.cdc.gov/reproductivehealth/unintendedpregnancy/ussspr.htm)
Unscheduled Bleeding with Extended or Continuous Use of COCs

- Extended contraceptive use is defined as a planned hormone-free interval after at least two contiguous cycles. Continuous contraceptive use is defined as uninterrupted use of hormonal contraception without a hormone-free interval.

- Unscheduled spotting or bleeding is common during the first 3–6 months of extended or continuous combined hormonal contraceptive use. It is generally not harmful and decreases with continued COC use.

- If clinically indicated, consider an underlying gynecological problem, such as inconsistent use, interactions with other medications, cigarette smoking, an STD, pregnancy, or new pathologic uterine conditions (e.g., polyps or fibroids).
  - If an underlying gynecological problem is found, treat the condition or refer for care.
  - If an underlying gynecological problem is not found and the woman wants treatment, the following treatment option can be considered:
    - Advise the woman to discontinue COC use (i.e. a hormone-free interval) for 3–4 consecutive days; a hormone-free interval is not recommended during the first 21 days of using the continuous or extended combined hormonal contraceptive method. A hormone-free interval also is not recommended more than once per month because contraceptive effectiveness might be reduced.

- If unscheduled spotting or bleeding persists and the woman finds it unacceptable, counsel her on alternative contraceptive methods, and offer another method if it is desired.

Vomiting or Severe Diarrhea

U.S. SPR Figure 5: Recommended Steps after Vomiting or Diarrhea while Using Combined Oral Contraceptives.
BIRTH CONTROL PILLS

COUNSELING HANDOUT

What are birth control pills?
Also called “oral contraceptives”, combined birth control pills contain two hormones, an estrogen and a progestin.

How do they work?
They stop the ovary from releasing an egg. They also thicken cervical mucus so sperm can’t enter the uterus and they thin the lining of the uterus.

How effective are they?
They are very effective. If taken perfectly only 3 women in 1,000 will get pregnant in one year. Typical use (some women have problems taking the pill on time) results in 90 women in 1,000 per year getting pregnant. So think about if you can remember to take the pill every day!

What are the advantages?
Decreases: Menstrual flow and anemia, menstrual cramps, endometriosis and PMS, benign breast conditions, ovarian and endometrial cancer risk, ovarian cysts, acne, pelvic inflammatory disease (PID), and ectopic pregnancy.

What are the disadvantages?
• Do not protect from HIV or other sexually transmitted infections. Use condoms if you are at risk.
• Need to take a pill every day and need a safe and convenient place to keep the pills.
• Possible nausea and/or spotting during the first few cycles. If you have nausea, take pill at night or with food.
• Other non-harmful side effects may be: dizziness, breast tenderness, headaches, mood changes, bloating.
• Most side effects resolve within 2-3 cycles of pills.
• Serious complications can occur but are rare: Blood clots, stroke, and heart attack. Risks for blood clots include older age, obesity and blood clotting disorders. Smoking is a risk factor for stroke and heart attack, so we do not use pills in women over 35 who smoke. Also non-cancerous liver tumors, gallbladder disease and high blood pressure can occur.
• After stopping pills, it’s possible you may not get your period for 1-3 months.

WARNING SIGNS: “ACHES”: Go to the Emergency Room if these symptoms develop:
A Abdominal pain, severe: could be: blood clot in pelvis or liver, benign liver tumor or gallbladder disease
C Chest pain or shortness of breath, severe: could be: blood clot in lungs, heart attack, angina (heart pain), or breast lump
H Headaches, severe: could be: stroke, migraine headache with nerve/brain signs (blurred vision, spots, zigzag lines, weakness, difficulty speaking), other headaches caused by pills, or high blood pressure
E Eye Problems: loss of, blurred, or double vision: could be: stroke, migraine headache with nerve/brain problems (blurred vision, spots, zigzag line), or blood clots in eyes
S Severe leg pain: could be: inflammation and blood clots of a vein in the leg

If at any time headaches clearly get worse or abnormal nerve or brain symptoms occur, stop pills immediately and see your nurse or doctor!

You should return to the clinic if you develop severe mood swings, depression, jaundice—(yellow-colored eyes or skin), miss 2 periods, or have signs of pregnancy.

Myths about birth control pills
Pills don’t cause birth defects, infertility or weight gain. They don’t build up in a woman’s body, won’t harm an early pregnancy and do not require a “rest” period.

Emergency Contraception: If you had sex and did not use contraception, call the clinic for Emergency Contraceptive Pills to prevent pregnancy up to 5 days after unprotected sex. You can also visit www.Not-2-Late.com for more information.
PÍLDORAS ANTICONCEPTIVAS

¿Qué son?
Son píldoras que combinan dos hormonas (estrógeno y progestina). Se las llama también “anticonceptivos orales”.

¿Cómo actúan?
Impide que haya ovulación. También hacen más espeso el moco cervical para que el esperma no pueda entrar al útero. Además, hace que el revestimiento del útero se vuelva más delgado.

¿Cuál es su eficacia?
Son muy eficaces. Si se toman correctamente, en un año de tomarlas sólo 3 de cada 1000 mujeres quedarán embarazadas. ¡Piensa en el beneficio de sólo tomar una píldora cada día!

¿Cuáles son las ventajas?
• La píldora disminuye el flujo y hay un menor riesgo de sufrir anemia, calambres menstruales, endometriosis y síndrome premenstrual. También es menor el riesgo de padecer problemas benignos en los senos, cáncer de ovario, cáncer de endometrio, quistes en los ovarios, acné, enfermedad pélvica inflamatoria o tener un embarazo extrauterino.

¿Cuáles son las desventajas?
• No protege contra el VIH y otras enfermedades de transmisión sexual. Si estás en riesgo de contraer una enfermedad de transmisión sexual, necesitas usar un condón.
• Debes tomar una píldora cada día, también necesitas un lugar seguro y conveniente para guardarlas.
• En los primeros ciclos menstruales después de empezar a tomar la píldora, puedes tener náuseas y sangrados parciales. Si tienes náuseas, toma la píldora en la noche o con alimentos.
• Otros efectos secundarios leves pueden ser mareos, dolores en los pechos, cambios de humor o sensación de hinchazón.
• La mayoría de los efectos secundarios desaparecen después de haber tomado 2-3 ciclos de píldoras.
• Aunque son raras, podrían darse complicaciones serias como: coágulos de sangre, derrame cerebral o ataque al corazón. La edad madura, obesidad y trastornos de coagulación pueden ser factores de riesgo para que se produzcan coágulos. Asimismo, el fumar aumenta el riesgo de sufrir derrames y ataques al corazón, por esta razón las mujeres mayores de 35 años no deben usar la píldora. También puede producir tumores no cancerosos del hígado, enfermedad de la vesícula e hipertensión.
• Después de dejar de usar las píldoras es posible que la menstruación no vuelva por 1 ó 3 meses.
SEÑALES DE ADVERTENCIA
Si tienes alguno de estos síntomas, vete a la sala de emergencias:

- **Dolor en la parte baja del estómago (abdomen):** Un dolor grave podría ser causado por un coágulo de sangre en la pelvis o en el hígado, por un tumor benigno en el hígado o por problemas de la vesícula.
- **Dolor en el pecho o problemas para respirar:** Si es grave, podrían ser coágulos en los pulmones, un ataque al corazón, angina (dolor del corazón) o un quiste en los senos.
- **Dolores graves de cabeza:** Podrían estar ocasionados por un derrame cerebral, migraña con señales nerviosas o cerebrales (vista borrosa, manchas, líneas en zigzag, debilidad, dificultad para hablar), otros dolores de cabeza causados por las píldoras o hipertensión.
- **Problemas de la vista:** La pérdida de visión o vista doble podría estar ocasionada por un derrame, migraña con problemas nerviosos o cerebrales (vista borrosa, manchas, líneas en zigzag) o coágulos de sangre en los ojos.
- **Dolores graves en las piernas:** Podría ser inflamación y coágulos de sangre en una vena de las piernas.

Si en algún momento los dolores de cabeza empeoran o aparecen síntomas nerviosos o cerebrales, deja la píldora de inmediato y consulta con un médico.

Deberías volver a la clínica si te aparecen cambios graves de humor, depresión, ictericia (cuando los ojos o la piel se ponen amarillos), si te faltaron dos menstruaciones o si tienes señales de un embarazo.

**Mitos sobre las píldoras anticonceptivas**
Las píldoras no causan defectos de nacimiento, infertilidad o aumento de peso. Las hormonas no se almacenan en el cuerpo de la mujer, no van a dañar un embarazo temprano y no requieren un período de “descanso”.

**¿Qué pasa si tengo sexo y no uso anticonceptivos?**
Client counseling handout #1: How to start taking birth control pills

How to start taking birth control pills.

There are three ways to start the pill. Your nurse or doctor will help you decide which way is best for you.

☐ First Day Start

Take the first pill in the pack on the first day that you bleed with your next period.

☐ Quick Start

Take the first pill in the pack today.

Use condoms or do not have sex for 7 days after you start.

☐ Sunday Start

Take the first pill in the pack on the first Sunday after you start bleeding.

If your bleeding starts on Sunday, that is the first Sunday. Take your pills that day.

Use condoms or do not have sex for 7 days after you start.

For all three start types—Quick Start, First Day Start, and Sunday Start—

After your first pill:

• Take one pill every day.
• Take your pill at the same time every day.
• Be careful not to skip pills.

Questions? Call your clinic at

( ) - 
Cómo empezar a tomar la pastilla anticonceptiva.

Hay tres maneras de empezar a tomar la pastilla. Su enfermera o doctor le ayudará a decidir la que es mejor para usted.

1. **Inicio en el primer día**
   - Tome la primera pastilla del paquete el primer día de sangrado de su próxima menstruación.

2. **Inicio rápido**
   - Tome la primera pastilla del paquete hoy.
   - Use condones o no tenga relaciones sexuales durante 7 días después de empezar a tomarlas.

3. **Inicio en domingo**
   - Si su sangrado empezó un domingo, ese se considera como el primer domingo.
   - Tome su primera pastilla ese día.
   - Use condones o no tenga relaciones sexuales durante 7 días después de empezar a tomarlas.

**Para cualquiera de los tres tipos de inicio—inicio rápido, inicio en el primer día o inicio en domingo—**

Después de su primera pastilla:
- Tome una pastilla todos los días
- Tome su pastilla a la misma hora todos los días
- Tenga cuidado de que no se le olvide tomar ninguna pastilla

¿Tiene preguntas? Llame a su clínica

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2.7 PROGESTIN-ONLY PILLS

A. EQUIPMENT
- Client educational counseling handout
- How to start taking birth control pills counseling handout
- What happens if you miss your birth control pills counseling handout
- Calendar
- Progestin Only Pills (POPs)

B. INDICATION
Progestin Only Pill is a reversible, hormonal method containing only a progestin and no estrogen that can be used by women of all ages. POP may be indicated for women who cannot tolerate estrogen or women who are exclusively breastfeeding.

Unlike COCs, POPs have vulnerable efficacy. To maximize contraceptive efficacy, POP users should be especially careful (more careful than COC users) to take the pills at the same time each day.

C. PRECAUTIONS AND CONTRAINDICATIONS
Medical conditions categorized as 3 or 4 in U.S. MEC.

For Category 3, the clinician will document client counseling of risks/benefits and reasons that the benefits outweigh the risk in the client medical record; for Category 4, do not provide the method.

D. HEALTH SCREENING/EXAM
1. Within the past 12 months, client must have on record a complete medical history as described in Section 1, Subsection 1.2.H.a Contraceptive Services.
2. If the client is changing methods of contraception, provide tiered approach contraceptive counseling and review the medical history with the client for new information. Assess any changes in health status, including medications.
3. Identify and record any allergies particularly to progestin.
4. Obtain baseline BP, wt/ht and BMI measurement as they are helpful for monitoring over time.

E. COUNSELING & EDUCATION
The client counseling handout can serve as the basic format for client education.

1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services.
2. Efficacy: With typical use, approximately 9 out of 100 women will become pregnant in the first year of use of POPs. With perfect use, only 3 women in 1,000 will get pregnant in one year.
3. Correct use/Risks/Benefits: Document counseling and client’s understanding in the record. Instructions for OCP use are at the end of the previous section. Instructions for missed POPs are at the end of this section.
   - One pill is taken every day with no hormone-free interval.
   - After ECP, begin POP 12 hours afterwards, or wait until first day of next period.
4. Missed pills education: A dose is considered missed if it has been more than 3 hours since it should have been taken. See Problem Management for SPR 2016 guidance.
5. Side effects: breakthrough bleeding and/or spotting, breast tenderness, mild headaches, nausea/vomiting (especially in the first few cycles) and mood changes. Side effects tend to be mild and transient. Advise to call as soon as a problem appears, not to discontinue the pills before consulting a nurse unless there are life-threatening symptoms below.
6. Warning Signs: Ascertain that the client has information about danger signs; see progestin only pills client counseling handout.
7. Caution women about STIs and encourage condom use if not in a monogamous relationship.
8. ECP information in the case that the client was more than 3 hours late taking the POP and had sexual intercourse.

F. CONSENT: Although Title X does not require a method-specific consent form for POPs, nurse/clinician must document the client’s recall and understanding of the counseling (based on the teach-back method) in the medical record.

G. PRESCRIPTION
1. CNP/CNM/PA or Physician must prescribe the method. They may prescribe up to a 12-month supply of POPs; 13 cycles of 28-day pill packs are needed for 12 months. A PHN may dispense the POPs to an established FPP client under a PHD clinician’s valid order.

The Clinician may also order ECP for future use at this time.

2. **Initiation Timing:** POPs can be initiated at any time if the clinician is reasonably certain that the woman is not pregnant. If uncertain whether the client might be pregnant, the benefits of starting POPs likely exceed any risk; therefore, starting POPs should be considered at any time with a follow-up pregnancy test in 2-4 weeks. For Special Considerations for Initiation of Progestin Only Pills, a clinician may refer to U.S. SPR.

3. **Need for Back-Up Contraception:**
   - If POPs are started within the first 5 days since menstrual bleeding started, no additional contraceptive protection is needed.
   - If POPs are started >5 days since menstrual bleeding started, the client needs to abstain from sexual intercourse or use additional contraceptive protection (foam/film and condoms) for the next 7 days.

H. VISIT SCHEDULE FOR METHOD
1. For clients who have never taken pills before, the pill supply shall be managed as follows:
   - Initial visit: 3 cycles - return for renewal during 3rd package.
   - Return visit: 10 cycles - return for annual visit during last package.

Pill supply for routine return clients should be managed as follows:
Annual visit for prescription: 13 cycles (packs) - return for the next annual visit before the last pack.

2. The nurse may make exceptions to the above visit when there are problems or with available POP supply or when a client needs to be monitored more closely (for example, teens). Document justification for the exception.

3. If there is a need to change the method, the nurse will need a clinician order.

4. Chart should include updated health history with particular attention to the last normal menstrual period, weight, BP and side effects/warning symptoms. Ask about difficulty using POP.

Clinician will document problems that were addressed.

I. PROBLEM MANAGEMENT (FOR CLINICIANS)
1. Clients who call or present with problems with the pills will be referred to a clinician. If no clinician is available and the nurse assesses the problem as severe, the client should be referred to a private physician or the Emergency Room.

2. **Recommended actions after late/missed pills:** For the following recommendations, a dose is considered missed if it has been >3 hours since it should have been taken. (SPR 2016).
   - Take one pill as soon as possible.
   - Continue taking pills daily, one each day, at the same time each day, even if it means taking two pills on the same day.
• Use back-up contraception (e.g., condoms) or avoid sexual intercourse until pills have been taken correctly, on time, for 2 consecutive days. (Some clinicians counsel to use condoms for 7 days, for consistency).

3. For vomiting/severe diarrhea (for any reason or duration) that occurs within 3 hrs after taking a pill:
   • Take another pill as soon as possible (if possible, despite discomfort).
   • Continue taking pills daily, one each day, at the same time each day.
   • Use back-up contraception (e.g., condoms) or avoid sexual intercourse until 2 days after vomiting or diarrhea has resolved.
   • EC should be considered if the woman has had unprotected sexual intercourse.
What Are Progestin Only Pills?
They are birth control pills that contain just one hormone, a progestin. They are also called “mini-pills” and can be used by women who shouldn’t use estrogen-containing pills.

How Do They Work?
They work by making cervical mucus thicker so sperm cannot reach the egg, and by making the lining of the uterus thinner. Sometimes they stop ovulation (release of egg).

How Effective Are They?
They are very effective. If taken perfectly only 3 women in 1,000 will get pregnant in one year. Typical use (some women have problems taking the pill at the same time each day) results in more pregnancies.

What are the advantages?
- They decrease menstrual flow and anemia, menstrual cramps, endometriosis, pelvic inflammatory disease (PID), endometrial and ovarian cancer.
- Usually can be used by women who cannot use estrogen-containing pills.
- Are easier to take than combined pills since every day you take the same kind of pill and there are no hormone-free pills.
- Nursing mothers can take progestin-only pills when the baby is 1 month old.
- Can be used by women who smoke and are over 35 years old.
- Ability to get pregnant returns quickly after stopping the pills.

What are the disadvantages?
- POPs do not protect you from HIV or other sexually transmitted diseases. Use condoms if you are at risk.
- Irregular bleeding is the most common problem. There may be spotting between periods, or periods may be very short and scanty.
- You have to remember to take a pill **around the same time (within 3 hours)** every single day.
- The failure rate is a bit higher than with regular birth control pills – but they are still very effective.

**Warning Signs!**
See your doctor or nurse if you have these or any other signs or concerns: severe abdominal pain, heavy bleeding, repeated, very painful headaches, or depression.

**Emergency Contraception**
If you had sex and did not use contraception, call the office for Emergency Contraception to prevent pregnancy up to 5 days after unprotected sex. You can also visit [www.Not-2-Late.com](http://www.Not-2-Late.com) for more information.
Píldoras de Progestina

¿Qué son?
Son píldoras anticonceptivas que contienen sólo una hormona, progestina. También se llaman “mini-píldoras” y las pueden usar mujeres que no deberían usar píldoras con estrógeno.

¿Cómo actúan?
Hacen que el moco cervical se haga más espeso para impedir que el esperma pueda llegar al óvulo y también hacen que el revestimiento del útero se vuelva más delgado. A veces impiden que haya ovulación (cuando el ovario expulsa un óvulo).

¿Cuál es su eficacia?
Son muy eficaces. Si se toman correctamente, en un año solamente 3 mujeres de cada 1000 quedarán embarazadas. El uso irregular (algunas mujeres tienen problemas en tomar la píldora a la misma hora cada día) aumenta las posibilidades de quedar embarazada.

¿Cuáles son las ventajas?
- Reducen el flujo, la anemia y los calambres menstruales, también disminuyen la posibilidad de desarrollar cáncer de endometrio o de ovarios, sufrir endometriosis o enfermedad pélvica inflamatoria.
- Pueden ser usadas por mujeres que no pueden usar píldoras con estrógeno.
- Son más fáciles de tomar que las píldoras combinadas, ya que cada día tomas el mismo tipo de píldora y no hay píldoras que no tengan hormonas.
- Las madres que están dando el pecho pueden comenzar a tomar estas píldoras cuando el bebé tiene un mes.
- Pueden ser usadas por mujeres fumadoras mayores de 35 años.
- La posibilidad de volver a quedar embarazada vuelve rápido después de dejar de tomar las píldoras.

¿Cuáles son las desventajas?
- No protegen contra el VIH y otras enfermedades de transmisión sexual. Si tú o tu pareja corren el riesgo de tener una enfermedad de transmisión sexual, usa condones.
- El problema más común es el sangrado irregular. Puede haber manchas de sangre entre las menstruaciones o las menstruaciones pueden ser muy cortas y escasas.
- Tienes que recordar tomar la píldora a la misma hora cada día (dentro de las tres horas).
- El riesgo de fallar es un poco mayor que con las píldoras comunes, pero aun así son muy eficaces.

¡Señales de advertencia!
Consulta con un médico o una enfermera si tienes algunos de estos síntomas: dolor grave en el abdomen, menstruación con sangrado abundante, dolor o sangrado continuo, repetidos y fuertes dolores de cabeza, o depresión. También consulta con un médico o una enfermera en caso de que haya otras cosas que te preocupen.

¿Qué pasa si tengo sexo y no uso anticonceptivos?
Llame a la oficina para conseguir Pastillas Anticonceptivas de Emergencia para prevenir el embarazo hasta 5 días después de que haya tenido sexo sin protegerse. También se puede visitar www.Not-2-Late.com para más información.
MISSED PILL INSTRUCTIONS FOR PROGESTIN-ONLY PILLS

This is what to do if you:

- Took your progestin-only pill less than 3 hours late
  1. Take the pill as soon as you remember.
  2. Take one pill every day, as before

- Missed 1 or more pills in a row (took your progestin-only pill more than 3 hours late)
  1. Take yesterday’s pill as soon as you remember. Also take today’s pill at the regular time AND use condom + foam (film) for 48 hrs or Don’t have sex for 48 hours
  2. Take one pill every day, as before

If your period does not start within 4 weeks, get a pregnancy test.
If you had sex without using protection, think about taking emergency contraceptive pills (ECP) right away. Call the Clinic or visit www.Not-2-Late.com for more information.

Instrucciones en el caso de no tomar las Píldoras de Progestina adecuadamente

Esto es lo que debes hacer si:

- Tomaste la píldora de progestina menos de 3 horas después de la hora debida
  1. Toma la píldora tan pronto como te acuerdes.
  2. Continúa tomando 1 píldora por día, como antes.

- Se te pasó tomar más de 1 píldoras en dos días seguidos (Tomaste la píldora de progestina más de 3 horas después de la hora debida)
  1. Toma la píldora de ayer tan pronto como te acuerdes. Toma la de hoy a la hora de costumbre y, si tienes relaciones sexuales, usa un condón por 48 horas o, No tengas relaciones sexuales por 48 horas
  2. Continúa tomando 1 píldora cada día, como antes.

Si tu menstruación no empieza en 4 semanas, hazte una prueba de embarazo.
Si tuviste relaciones sexuales sin usar la protección indicada arriba, considera tomar enseguida píldoras anticonceptivas de emergencia en cuanto sea posible. Para más información o para obtener los números telefónicos de las clínicas más cercanas que receten las píldoras anticonceptivas de emergencia, se puede visitar www.Not-2-Late.com para más información.

U.S. Selected Practice Recommendations, 2016
2.8 CONDOMS, MALE

A. EQUIPMENT

• Client counseling handout or brochure
• Model of penis and pelvis
• Sample male condoms

B. INDICATION

Clients who are using another contraception method but who have more than one partner, or whose partner has had more than one partner, or uses IV drugs, or engages in other behaviors associated with STIs should be advised to use condoms. Clients should be informed about both male and female condoms.

C. PRECAUTIONS AND CONTRAINDICATIONS

1. Clients with latex allergy should use only non-latex condoms.
2. Oil-based lubricants may damage latex male condoms.

D. HEALTH SCREENING/EVALUATION

1. Males requesting condoms do not need a medical history or physical but should be offered this service. All men should be made aware of services available through the health office and encouraged to use them as appropriate.

2. Women requesting condoms should be counseled and offered a more effective birth control method to use with condoms i.e. consider dual-method. If client decides to use a more effective method, follow the protocol for that particular method.

3. Identify and record any allergies particularly to latex. Clients are encouraged to return for evaluation if they experience symptoms of genital rash or irritation using condoms.

E. COUNSELING & EDUCATION

The client counseling handout and condom brochure can serve as the basic format for client education.

1. Efficacy: With typical use, approximately 18 out of 100 women will become pregnant in the first year of use. With perfect use, 2 women in 100 will get pregnant.

2. Correct use/Risks/Benefits: Document counseling and client’s understanding in the record. Demonstrate proper use of condoms. Latex condoms when used consistently and correctly are highly effective in preventing transmission of HIV. Correct and consistent use of latex condoms can reduce the risk of other STIs.

3. Educate about ECP.

F. CONSENT: No informed consent is required for this method.

G. PRESCRIPTION/DISPENSING

The number of condoms to be dispensed depends upon the client's particular needs.

H. VISIT SCHEDULE FOR METHOD: Routine visits are suggested.
Condoms for Men

Condoms for men can be made out of latex, plastic, or natural materials such as sheep intestines. There are condoms made of polyurethane: these may be used by people who are allergic to latex. The condom is put onto the penis before the penis comes into contact with the vagina. This keeps the sperm from going into the vagina.

What are the advantages of using condoms?
- They can prevent sexually transmitted infections when used for all oral, vaginal, or anal sex.
- You may enjoy sex more because there is less fear of infections or pregnancy.
- Men “last longer” when they use condoms.
- Condoms come in many colors, sizes and textures.
- Condoms make sex less messy.
- If the woman puts the condom on the man, it can be fun for both!
- Condoms may reduce cervical cancer because there’s less risk of HPV infection.
- You don’t need to go to the clinic or doctor to get a condom.
- Condoms are easy to get. They don’t cost too much.
- Condoms are a good choice for back-up birth control.

What are the disadvantages of using condoms?
- Condoms may not be available when a couple needs one.
- If you don’t plan ahead, using a condom may interrupt sex.
- You need to learn how to use condoms. This may take practice.
- You need to take care not to tear or break the condom.
- You can’t use oil-based lubricants such as Vaseline, sun tan oil, whipped cream or Crisco with latex condoms! These products can put a hole in a latex condom in seconds.
- Some men cannot keep an erection with a condom on.
- The man must pull out soon after he comes. If he becomes soft, the condom can fall off. Sperm can then seep into the vagina and cause pregnancy.
- Some people may find the smell of latex condoms unpleasant.
- For preventing pregnancy, animal skin condoms can be used for people with latex allergies, but can be less effective. Polyurethane condoms are an alternative. Both types cost more than latex condoms.
- Buying, putting on, talking about, and getting rid of condoms may be embarrassing for some people.
- You may not enjoy sex as much because of decreased feeling.

Other Tips:
- Penises and condoms come in different sizes! Find a condom that fits!
- Use a condom every time you have sex.
- If you like to use lubricants, use water based lubricants such as Astroglide, Aqua Lube or KY Jelly. This will cut down on the chances of your condom breaking.
- Pull the penis out of the vagina right after the man comes. Don’t continue thrusting until the penis becomes soft.
- For increased pregnancy protection, a man can use a condom at the same time as a woman uses spermicidal foam, film or vaginal suppositories.

Where do I get condoms? Condoms can be bought at any drugstore. Many supermarkets and gas stations sell them too. Some health departments and family planning clinics give away condoms.

What if I have sex and don’t use birth control?
Call the office for Emergency Contraceptive Pills to prevent pregnancy up to 5 days after unprotected sex. You can also visit www.Not-2-Late.com for more information.
**Condones para hombres**

Los condones pueden estar hechos de látex, de materiales naturales como los intestinos de borrego o de poliuretano. Las personas que son alérgicas al látex pueden usar los condones de poliuretano. El condón se coloca sobre el pene antes de que éste entre en contacto con la vagina. Esto evita que el esperma entre en la vagina.

¿Cuáles son las ventajas de usar condones?

- Pueden prevenir las infecciones transmitidas sexualmente cuando se usan cuando se tiene todo coito: oral, vaginal o anal.
- Puedes disfrutar más el sexo porque hay menos temor de infecciones o embarazo.
- Cuando usan condones, los hombres pueden “durar más”.
- Los condones vienen en muchos colores, tamaños y texturas.
- Si la mujer le pone el condón al hombre, puede ser divertido para los dos.
- Los condones pueden reducir el riesgo de cáncer de cuello de útero, porque hay menos riesgo de contraer el virus de papiloma humano (VPH).
- No necesitas ir al doctor o a una clínica para obtener condones.
- Los condones son fáciles de conseguir y no cuestan mucho.
- Se pueden usar como método de refuerzo junto con otro método anticonceptivo.

¿Cuáles son las desventajas de usar condones?

- Es posible que los condones no estén a la mano cuando la pareja necesita uno.
- Si no es parte del juego amoroso, el colocar el condón puede interrumpir el acto sexual.
- Necesitas aprender cómo usar los condones y esto puede requerir práctica.
- Debes tener cuidado de no romper o rasgar el condón.
- Con los condones de látex, no puedes usar lubricantes con base de aceite, tales como Vaseline, crema batida o Crisco, ya que en unos pocos segundos estos productos pueden hacer un agujero en un condón de látex.
- Algunos hombres no pueden tener una erección si se ponen un condón.
- El hombre debe sacar el pene de la vagina tan pronto como eyacula. Si el pene se pone blando, el condón se puede salir. El esperma puede caer en la vagina y causar un embarazo.
- A algunas personas el olor del condón de látex les resulta desagradable.
- Para prevenir el embarazo, los condones de piel de animal pueden ser usados por las personas que tienen alergias al látex, pero pueden ser menos eficaces. Los condones de poliuretano son una alternativa. Las dos clases cuestan más que los condones de látex.
- A algunas personas les causa vergüenza comprar, ponerlos, hablar acerca de ellos o deshacerse de los condones.
- Tal vez no disfrutes tanto del sexo, porque disminuye las sensaciones.

**Otros consejos**

- Los penes y los condones vienen en diferentes tamaños. Encuentra el que más te convenga.
- Usa un condón nuevo cada vez que tengas relaciones sexuales.
- Si te gustan los lubricantes, usa lubricantes con base de agua, como Astroglide, Aqualube o jalea KY para reducir la posibilidad de que el condón se rompa.
- Es importante quitar el pene de la vagina inmediatamente después de que el hombre eyacula y no esperar, porque sino el esperma se puede salir.
- Practica colocando el condón. Esto va a hacer más fácil usar los condones durante el acto sexual.
- Para aumentar la protección en contra de un embarazo, el hombre puede usar un condón al mismo tiempo que la mujer usa una espuma espermicida, una película o supositorios vaginales.

¿Dónde compro los condones?

Los condones se pueden comprar en cualquier farmacia. Muchos supermercados y gasolineras también los venden. Algunos departamentos de salud pública y clínicas de planificación familiar los regalan.

¿Qué pasa si tengo sexo y no uso anticonceptivos? Llame a la oficina para conseguir Pastillas Anticonceptivas de Emergencia para prevenir el embarazo hasta 5 días después de que haya tenido sexo sin protegerse. También se puede visitar www.Not-2-Late.com para más información.
2.9 CONDOMS, FEMALE

A. EQUIPMENT

- Client counseling handout for female condom
- Sample female condom
- Model of female pelvis

B. INDICATION

Female condom is a female-controlled method and provides some protection to the labia and base of the penis during intercourse.

C. PRECAUTIONS AND CONTRAINDICATIONS

1. The woman or man is allergic to polyurethane or the silicon-based lubricant.
2. Abnormality in vaginal anatomy interferes with a satisfactory fit or stable placement of the female condom.
3. Lubricant in the female condom is oil-based and may damage latex male condoms if used together. Female and male condoms should not be used together.

D. HEALTH SCREENING/EXAM

1. Women requesting female condoms as their primary birth control method should be counseled and offered a more effective method. If client decides to use a more effective method, follow the protocol for that particular method.
2. At a minimum, client must have the following history on record within the past 12 months:
   - A reproductive life plan
   - Contraceptive experiences and preferences
   - Sexual health history.
3. Obtain baseline BP, wt/ht and BMI measurement as they are helpful for monitoring over time.

E. COUNSELING & EDUCATION

The client counseling handout can serve as the basic format for client education.

1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services, particularly using tiered approach contraceptive counseling.
2. **Efficacy:** With typical use, approximately 21 out of 100 women will become pregnant in the first year of use. With perfect use, 5 women in 100 will get pregnant.
3. **Correct use/Risks/Benefits:** It is a soft loose fitting polyurethane sheath with inner and outer flexible rings. It is coated with a silicone based lubricant that does not contain a spermicidal agent. Encourage clients to insert a female condom on their own outside of a sexual encounter, to become familiar with its use. If the client chooses to continue using this method, she/he may continue receiving supplies based on patterns of use and availability.

F. CONSENT: No consent is required for this method.

G. PRESCRIPTION/DISPENSING

It may take more than one or two uses to become familiar and comfortable with its use. Therefore, three condoms should be provided for first-time users. Otherwise, the number of condoms to be dispensed depends upon the client's particular needs.

H. VISIT SCHEDULE FOR METHOD

Routine visits are suggested. Clients are encouraged to return for evaluation if they experience symptoms of genital rash or irritation using the female condom.
What is the Female Condom?

Female condoms are made of thin plastic called polyurethane, not latex or rubber. It is placed into the woman’s vagina. It is open at one end and closed at the other. Both ends have a flexible ring used to keep the condom in the vagina. The flexible inner ring at the closed end is put into the vagina as far as possible. (You can take the inner ring out if it is uncomfortable.) The larger outer ring stays outside the vagina. Among women who start using the female condom, about 21% will get pregnant the first year. If the condom is used right each time, only about 5% of women will get pregnant.

What are the Advantages of the Female Condom?

- It can help protect against both sexually transmitted infections (STIs) and pregnancy.
- If your partner doesn’t want to use a male condom, you can use a female condom.
- Your partner can insert it and make it part of lovemaking.
- You can use any kind of lubricant even oil-based lubricants.
- Although it looks different, its size and shape allow it to protect a greater area.
- It is rare for them to break

What are the Disadvantages of the Female Condom?

- Some women do not like the idea of putting fingers or a foreign object into their vagina.
- It can be large, bulky, and can be difficult for some women to place into vagina.
- It will not work if the man’s penis enters the vagina outside of the female condom.
- The penis must be directed into the condom.
- It can make rustling noises prior to or during intercourse. A lubricant may decrease noises.
- The female condom is not available in as many stores as the male condom.
- Female condoms are about three times more expensive than male condoms.
- The female condom is less effective than latex male condoms in preventing both pregnancy and STIs.

What if I have sex and don’t use birth control?

Call the office for Emergency Contraceptive Pills to prevent pregnancy up to 5 days after unprotected sex. You can also visit www.Not-2-Late.com for more information.
¿Qué es el condón para mujeres?

Los condones para mujeres están hechos de un plástico delgado llamado poliuretano. Esto no es látex o caucho. El condón se coloca dentro de la vagina. Está abierto en un extremo y cerrado en el otro. Los dos extremos tienen un anillo flexible para mantener el condón en la vagina. El anillo flexible en el extremo cerrado se empuja dentro de la vagina tanto como sea posible (puedes quitar el anillo interior si resulta incómodo). El anillo exterior, más grande, queda fuera de la vagina. Entre las mujeres que comienzan a usar el condón femenino, alrededor del 21% quedan embarazadas en el primer año. Si el condón se usa correctamente cada vez, sólo el 5% de las mujeres quedarán embarazadas.

¿Cuáles son las ventajas del condón femenino?

- Ayuda a proteger contra enfermedades de transmisión sexual y embarazos.
- Si tu pareja no quiere usar un condón para hombres, tú puedes usar el condón femenino.
- Tu pareja lo puede insertar y hacerlo parte del juego amoroso.
- Aunque se ve diferente, su tamaño y forma le permite proteger un área más grande.
- Puedes usar con él cualquier tipo de lubricantes, incluso los que tienen base de aceite.
- Da calor. Esto hace más divertido el sexo.
- Es raro que se rompan.

¿Cuáles son las desventajas del condón femenino?

- A algunas mujeres no les gusta la idea de poner los dedos o un objeto extraño dentro de su vagina.
- Puede ser grande, voluminoso y, para algunas mujeres, difícil de colocar en la vagina.
- No funcionará si el pene entra en la vagina fuera del condón. El pene debe ser dirigido al condón.
- Puede hacer ruidos particulares antes o durante el acto sexual. Un lubricante puede reducir el nivel del ruido.
- El condón femenino no se consigue en tantos lugares como el condón masculino.
- Los condones femeninos son 3 veces más costosos que los condones masculinos.
- El condón femenino es menos eficaz en prevenir embarazos y enfermedades sexuales que los condones masculinos de látex.

¿Qué pasa si tengo sexo y no uso anticonceptivos?

Llame a la oficina para conseguir Pastillas Anticonceptivas de Emergencia para prevenir el embarazo hasta 5 días después de que haya tenido sexo sin protegerse. También se puede visitar www.Not-2-Late.com para más información.
2. 10 FERTILITY AWARENESS-BASED METHODS

A. EQUIPMENT

- Standard Days Method - Cycle Beads and package insert (directions for use) or smart-phone app
- Calendar
- TwoDay Method® - smart-phone app or website instructions

B. INDICATIONS

Fertility Awareness-Based (FAB) methods of family planning depend on identifying the “fertile window,” or the days in each menstrual cycle when intercourse is most likely to result in a pregnancy. Knowledge of these methods can help couples understand how to avoid pregnancy or how to become pregnant. FAB methods are enhanced when couples agree on how the method will be used. For this reason, couple’s counseling is strongly recommended.

C. PRECAUTIONS AND CONTRAINDICATIONS

The US MEC classification system for fertility awareness-based methods uses the three recommendation categories of ‘delay’, ‘caution’, or ‘accept’. While there are no medical conditions that are worsened with use of fertility awareness-based methods, some conditions or characteristics may make the use of these methods more difficult. In such cases, the use of these methods may better be delayed until the condition is resolved or that special training is needed for correct use of the method. Specific conditions that would make symptom-based methods and calendar-based methods more difficult to use are listed in the US MEC Appendix H.

D. HEALTH SCREENING/EXAM

1. Within the past 12 months, client must have on record a complete medical history as described in Section 1, Subsection 1.2.H.a Contraceptive Services.
2. If the client is changing methods of contraception, provide contraceptive counseling and review the medical history with the client for new information. Assess any changes in health status, including medications.
3. Obtain baseline BP, weight/height and BMI measurement as they are helpful for monitoring over time.

E. COUNSELING & EDUCATION

The client counseling handout can serve as the basic format for client education.

1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services.
2. Correct use/Risks/Benefits: Document counseling and client’s understanding in the record.
   If clinic is too busy for a detailed session, invite the client to return at a better time. Provide educational materials to prepare for the counseling visit. Encourage her to bring her partner.

   Standard Days Method (SDM) is most appropriate for women who usually have cycles between 26 and 32 days long. If the woman has 2 or more menstrual cycles that were less than 26 or more than 32 days within a year of SDM use advise the woman that the method might not be appropriate for her because of a higher risk of pregnancy. Help her consider another method.

   Most couples who use the SDM use a specially-designed color-coded string of beads called “CycleBeads” or smartphone app to help them keep track of the woman’s cycle days.
   - Days 1-7: can have unprotected intercourse.
   - Days 8-19: use a barrier method or abstain.
Days 20-menses: can have unprotected intercourse.

**Efficacy:** typical use will result in 12 pregnancies per 100 women years. Perfect use will result in 5 pregnancies per 100 women years.

If they have unprotected sexual intercourse during days 8-19, they may consider the use of ECP. This method can also be used to help a couple achieve pregnancy. Complete instructions are found in the package insert or app.


**TwoDay Method®** is based on the presence or absence of cervical secretions. Women must check secretions in underwear, on the vulva or a sensation of vulvar wetness daily. If a woman notices cervical secretions of any type ‘yesterday’ or ‘today’, she considers herself fertile today. If she did not notice any secretions yesterday or today, she considers herself not fertile today (Contraceptive Technology 20th Ed.).

**Efficacy:** typical use will result in 14 pregnancies per 100 woman years. Perfect use will result in 4-6 pregnancies per 100 women years.

To prevent pregnancy, avoid unprotected intercourse on fertile days.

If they have continuous secretions for more than two weeks, or secretions that are malodorous or irritating, they should be counseled that they may have an infection that requires medical attention and should contact your health care provider.

Additional information can be found in Contraceptive Technology, 20th Ed., or at [http://www.twodaymethod.com/](http://www.twodaymethod.com/) or [https://www.k4health.org/toolkits/twoday](https://www.k4health.org/toolkits/twoday) or on the TwoDay Method® App.

**Applications (apps) for smart-phones** (iPhone, Android-based) provide another tool for those interested in using fertility-based awareness as part of their contraception or pregnancy planning. These tools may be used to:

- Avoid pregnancy using FAB methods e.g., teens who are not ready to take hormonal contraceptives and would like to continue using barrier method(s), this will help enhance the efficacy of the barrier method(s);
- Maximize the chances of getting pregnant;
- Help plan (e.g., travel with future menstruation and ovulation dates predicted); and
- Track weight, headache, appetite, PMS and other menstrual symptoms.

3. It is appropriate to offer the CycleBeads to clients, such as teens, who are simply curious about the fertility cycle and wish to know more about how their bodies function.

4. Some communities have agencies that specialize in FAB methods and may be a source for referral and counseling.

5. For information on Lactational Amenorrhea Method, please refer to Section 5.

**F. CONSENT:** No consent form is required.

**G. VISIT SCHEDULE FOR METHOD**

No routine follow-up visit is required although clients should be informed of the need for routine gynecological check-ups. Advise client to return:

- At any time to discuss the method or problems.
- If she wants to change the method being used.
Sample Smartphone Apps  
*OPTIONAL COUNSELING TOOL*  
*(free except those with a price notation)*  

<table>
<thead>
<tr>
<th>Feature</th>
<th><strong>Android Program</strong> (available at Android Market)</th>
<th><strong>iPhone</strong> (available through iTunes and online sites)</th>
</tr>
</thead>
</table>
| Ovulation and fertile days               | PT = Period Tracker  
PP = Pink Pad  
WL = Woman Log  
MD = My Days  
LC = Lady Cycle  
FF = Fertility Friend  
LoC= Love Cycle | MC = MyCycles  
PT = Period Tracker  
PP = Pink Pad  
PeP = Period Plus |
| Fertility awareness methods (FAM)        | OvuView – 14 FAM incl Standard days  
iC = iCycleBeads - Standard days  
Cost: $2.99 | iC = iCycleBeads - Standard days  
Cost: $2.99 |
| Body temp tracking                       | WL  
MD  
FF  
LoC | NFP = NFP Manager –Sympto  
MC |
| Cervical mucus tracking                  | FF  
TwoDay Method | NFP  
MC |
| Notifications (period, fertile)         | PP  
WL  
iC  
Cost: $2.99 | PP  
iC  
Cost: $2.99 |
| Languages other than English (incl Spanish) | WL  
MD | |
| Logs of dates and calculates average days of past menstrual cycles | PP  
PT  
WL  
FF  
iC  
Cost: $2.99, LoC | PP  
PT  
MC  
iC  
Cost: $2.99 |
| Shows future period dates                | PP  
PT  
WL  
MD  
LC  
FF  
LoC | PP  
PT  
PeP  
MC |
| Privacy feature (e.g., password protection) | PT  
WL  
LC  
FF  
LoC | PT  
PeP |
| Weight tracking                          | PP  
WL  
LoC | PP  
PeP |
| Provide education/hints                  | OV  
LC | |

**Birth Control Method**  

<table>
<thead>
<tr>
<th><strong>Android Program</strong> (available at Android Market)</th>
<th><strong>iPhone</strong> (available through iTunes and online sites)</th>
</tr>
</thead>
</table>
| Birth Control Pill                                | PillReminder  
ContraceptivePill | myPill  
MyReminder  
Cost: $0.99 |
| Birth Control Ring                                | Contraceptive ring | RingRemind |
| Birth Control Patch                               | Contraceptive Patch | |
2.11 **CONTRACEPTIVE SPERMICIDE (FILM OR FOAM)**

A. **EQUIPMENT**
   - Sample contraceptive foam and applicator
   - Sample vaginal contraceptive film (VCF)
   - Plastic female pelvis

B. **INDICATION**
   Vaginal spermicides are indicated for dual use with condoms or fertility awareness-based methods to provide higher contraceptive efficacy. *When used alone, they have a high failure rate. Long term use as a primary method should be discouraged.*

C. **PRECAUTIONS AND CONTRAINDICATIONS**
   1. Sensitivity/allergy to spermicide.
   2. Although these methods are relatively simple to use, they require more instruction and counseling from providers than do other methods.
   3. Vaginal spermicides containing nonoxynol-9 (N-9) are not effective in preventing cervical gonorrhea, chlamydia, or HIV infection. Frequent use (2 times or more per day) of spermicides containing N-9 has been associated with disruption of the genital epithelium, which might be associated with an increased risk for HIV transmission. Therefore, N-9 is not recommended for STD/HIV prevention. (CDC STD Treatment Guidelines and Contraceptive Technology)

D. **HEALTH SCREENING/EXAM**
   1. Women requesting spermicide as a primary method should be counseled/offered a more effective method. If client decides to use a more effective method, follow the protocol for that method.
   2. At a minimum, client must have the following history on record within the past 12 months:
      - A reproductive life plan
      - Contraceptive experiences and preferences
      - Sexual health history.
   3. Obtain baseline BP, wt/ht and BMI measurement as they are helpful for monitoring over time.

E. **COUNSELING & EDUCATION**
   The client counseling handout can serve as the basic format for client education.
   1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services, particularly using tiered approach contraceptive counseling.
   2. **Efficacy** when used alone: With typical use, approximately 28 out of 100 women will become pregnant in the first year of use. With perfect use, 18 women in 100 will get pregnant.
   3. **Correct use/Risks/Benefits:** Inform about benefits, risks, correct use and adverse effects.
      - Demonstrate proper use of film/foam.
   4. Educate about ECP.

F. **CONSENT:** No informed consent is required for this method.

G. **PRESCRIPTION/DISPENSING**
   The amount of spermicide to be dispensed at a clinic visit depends upon the client's particular needs. The VCF is to be dispensed in units of 12. The foam is to be dispensed in 1-2 units.

H. **VISIT SCHEDULE FOR METHOD**
   No routine follow-up visit is required although clients should be informed of the need for routine gynecological check-ups. Advise client to return:
   - At any time to discuss the method or problems e.g., genital rash or irritation using spermicides.
   - If she wants to change the method being used.
What is Vaginal Contraceptive Film/Foam?

**Contraceptive film** is a 2-inch by 2-inch clear, paper-thin sheet with a chemical that kills sperm. It dissolves in seconds. The film is placed on or near the cervix which is the opening of the uterus. It should be put in at least 15 minutes before you have sex.

**Contraceptive foam** is placed into the woman’s vagina using an applicator, like putting in a tampon.

The chemical in contraceptive film/foam, also called a spermicide, is Nonoxynol - 9. It works in 2 ways:
- It kills sperm.
- It blocks sperm from entering the cervix.

About 28% of women using vaginal films and other spermicides will get pregnant during the first year. If these spermicides are used right and each time you have sex, only about 18% of women will get pregnant.

**What are the advantages?**
- Safe, no hormones are involved.
- Gives women control over contraception.
- Your partner’s penis can remain inside the vagina after he comes.
- Simple to use, not messy, no discharge.
- You can’t tell it’s there.
- Available at most drug stores.
- Can be used alone or with a condom.
- When film/foam and condoms are used together correctly each time you have sex, they work almost as well as birth control pills to prevent pregnancy.
- Can be used during breastfeeding.
- Because it lubricates you, it may make sex more enjoyable for you and your partner.

**What are the disadvantages?**
- You need to use another one each time you have sex.
- You need to wash your hands with soap and water before putting your film in.
- You need to dry your hands carefully or the film will stick to your fingers.
- Putting it in may interrupt sex.
- Some people may be sensitive to film/foam or find it causes irritation. This may increase your chances of sexually transmitted infections (STIs) or urinary tract infections.
- It doesn’t work as well as other birth control methods.
- If you or your partner is at risk of STIs or HIV, you need to use a condom.

**Where do I get Film/Foam?**
You can buy it at drug stores and some supermarkets. It is also available at most health department and family planning clinics.

**Other tips:**
- Practice putting film/foam into your vagina before you have sex. This will make it easier when you’re ready to have sex.
- Keep an extra can of foam handy in case you run out.

**What if I have Sex and Don’t Use Birth Control?**
Call the office for Emergency Contraceptive Pills to prevent pregnancy up to 5 days after unprotected sex. You can also visit [www.Not-2-Late.com](http://www.Not-2-Late.com) for more information.
¿Qué es la lámina vaginal/la espuma anticonceptiva?

La lámina vaginal anticonceptiva es una lámina clara como de papel que mide 2 x 2 pulgadas. Contiene una sustancia química que mata el esperma. Se disuelve en unos pocos segundos. La lámina vaginal se coloca en el cuello del útero. Debe colocarse por lo menos 15 minutos antes del acto sexual.

La espuma se coloca en la vagina con un aplicador. Es como colocar un tampón.

La sustancia en la lámina vaginal/la espuma, también llamada espermicida, es nonoxinol-9. La lámina vaginal/la espuma anticonceptiva funciona de 2 maneras:
- Mata el esperma.
- Bloquea el esperma para que no entren al cuello del útero.

Cerca del 28% de las mujeres que usan éste u otros espermicidas vaginales quedarán embarazadas en el primer año. Si estos espermicidas se usan correctamente y cada vez que se tienen relaciones sexuales, sólo el 18% de las mujeres quedarán embarazadas.

¿Cuáles son las ventajas?
- Es un método seguro. No contiene hormonas.
- Les da a las mujeres el control sobre la anticoncepción.
- El pene de tu compañero puede quedar dentro de la vagina después de eyacular.
- Es de uso simple. No crea una sensación desagradable ni tampoco produce secreciones de ningún tipo.
- No causa incomodidad ya que no se siente adentro.
- Se puede comprar en la mayoría de las farmacias.
- Se puede usar solo o junto con un condón.
- Cuando la lámina vaginal/la espuma anticonceptiva y los condones se usan juntos, correctamente, cada vez que se tienen relaciones sexuales, trabajan casi tan bien como las píldoras anticonceptivas.
- Lo puedes usar si estás dando el pecho.
- Debido a que te lubrica, puede hacer que tú y tu compañero disfruten más de las relaciones sexuales.

¿Cuáles son las desventajas?
- Se necesita colocar una nueva lámina/espuma cada vez que se tienen relaciones sexuales.
- Te tienes que lavar las manos con agua y jabón antes de colocarlo.
- Necesitas secarte las manos con cuidado, sino la lámina vaginal se pegará a tus dedos.
- Colocarlo puede interrumpir el acto sexual.
- Algunas personas pueden sentir sensibilidad o éste les pueda causar irritación. Esto puede aumentar las posibilidades de contrainfecciones de transmisión sexual o infecciones urinarias.
- No trabaja tan bien como otros métodos anticonceptivos.
- Si tú o tu pareja están en riesgo de contraer una infección o el VIH/ SIDA, necesitas usar un condón.

¿Dónde puedo comprar la lámina vaginal/la espuma?
La puedes comprar en farmacias y en algunos supermercados. También la puedes obtener en muchos departamentos de salud pública y en clínicas de planificación familiar.

Otros consejos:
* Practica colocando la lámina vaginal/la espuma en tu vagina antes de tener relaciones sexuales. Será más fácil cuando estés lista para tener relaciones sexuales.
* Siempre ten un recipiente de espuma en reserva, en caso de que se te acabe.

¿Qué pasa si tengo sexo y no uso anticonceptivos?
Llame a la oficina para conseguir Pastillas Anticonceptivas de Emergencia para prevenir el embarazo hasta 5 días después de que haya tenido sexo sin protegerse. También se puede visitar www.Not-2-Late.com para más información.
INSTRUCTIONS FOR THE USE OF CONTRACEPTIVE FOAM

HOW TO USE FOAM:

When purchasing foam, be sure the package says that it is used to prevent pregnancy, and read the manufacturer’s instructions carefully. Be sure to shake the can of foam very well (at least 20 times) before you fill the applicator. Completely fill the applicator; put the full applicator of foam into your vagina while lying on your back, right before you have intercourse. (If you do not have intercourse within 20 minutes after you insert the foam, insert another applicator of foam right before you do have intercourse.)

Use additional applicator of foam each time before intercourse.

Wash your applicator after each use.

Occasionally, the foam will cause itching and burning in the vagina. If this happens, discontinue use and call the Family Planning clinic. If pregnancy is suspected, do not use foam.

FOR MAXIMUM PROTECTION, USE CONDOMS AND FOAM TOGETHER.

If at any time you have questions or concerns relating to your birth control method, call the Family Planning clinic.

INSTRUCCIONES PARA EL USO DE LA ESPUMA

COMO USAR LA ESPUMA:

Al comprar la espuma, asegúrese que el paquete diga que se usa para prevenir el embarazo, y lea las instrucciones del fabricante cuidadosamente. Procure agitar bien el envase de la espuma (por lo menos veinte veces) antes de llenar el aplicador. Llene el aplicador completamente; coloque el aplicador lleno en su vagina al estar acostada de espaldas, inmediatamente antes del acto sexual. (Si no se realiza el acto sexual 20 minutos después de ponerse la espuma, póngase otro aplicador de espuma inmediatamente antes del acto sexual).

Use otro aplicador de espuma antes de cada acto sexual. Lave el aplicador después de cada uso.

A veces la espuma puede causar comezón y ardor en la vagina. Si esto sucede deje de usarlo y llame a la Oficina de Salud. Si se sospecha el embarazo NO USE LA ESPUMA.

PARA PROTECCIÓN MÁXIMA, USE LOS CONDONES JUNTO CON LA ESPUMA.

Cuando tenga preguntas o preocupaciones acerca de su método anticonceptivo, llame a la oficina de salud.
2.12 ABSTINENCE

A. EQUIPMENT

Abstinence materials

B. INDICATION

Candidates for use include individuals or couples who feel they have the ability to refrain from sexual intercourse. Abstinence can be a wise and healthy choice at any life stage (particularly when a person does not feel ready for sexual involvement or a relationship). Sexual activity should always be mutually agreed upon; sexual coercion is unhealthy at any age.

C. PRECAUTIONS AND CONTRAINDICATIONS

A back-up method should always be planned.

D. HEALTH SCREENING/EXAM

1. At a minimum, client must have the following history on record within the past 12 months:
   • A reproductive life plan
   • Contraceptive experiences and preferences
   • Sexual health history e.g., past STD history, partner history.

2. Obtain baseline BP, wt/ht and BMI measurement as they are helpful for monitoring over time.

E. COUNSELING & EDUCATION

The client counseling handout can serve as the basic format for client education.

1. Clients will be counseled as outlined in Section 1, Subsection 1.2.H.a Contraceptive Services.

2. **Efficacy:** Periodic abstinence failure rate is estimated at 22%. Perfect use failure rate is 0%.

3. Inform about advantages and disadvantages.

4. Educate about ECP.

F. CONSENT: No consent is required for this method.

G. VISIT SCHEDULE FOR METHOD

No routine follow-up visit is required although clients should be informed of the need for routine gynecological check-ups. Advise client to return:

• At any time to discuss the method or problems.

• If she wants to change the method being used.
What is Abstinence?

COUNSELING HANDOUT

For most people abstinence means avoiding sexual intercourse. Your reasons for waiting will affect what abstinence means to you. Some people abstain for one night. Others abstain over a longer period of time. You can have sex one time and change your mind for the next time. The decision is yours.

What are the advantages of abstinence?

- Anyone can use it at any time in their life.
- It’s free and has no medical side effects.
- If used perfectly, it prevents pregnancy and sexually transmitted infections.
- It can be an empowering choice.

What are the disadvantages of abstinence?

- Know what you mean by “abstinence”. Understand your limits and why you want to wait.
- It requires planning (pick a time and place to talk to your partner about your beliefs beforehand).
- Sticking with the choice to be abstinent can be challenging if you’re pressured to have sex. (It’s easier to stick to a decision if you think ahead and have ideas about how to deal with pressure).
- There is a high failure rate (approximately 22%) if not practiced correctly every time.

Where can I learn more?

Discuss your decision with your partner and/or another person whom you trust and respect. Some churches and other sex education programs have support groups or classes for young people who want to wait until they get married before they have sex, or who want to learn and practice refusal skills.

What if I have sex and don’t use birth control?

Call the office for Emergency Contraceptive Pills to prevent pregnancy up to 5 days after unprotected sex. You can also visit www.Not-2-Late.com for more information.
¿Qué es la abstinencia?

HERRAMIENTA PARA CONSEJERÍA

Para muchas personas la abstinencia significa evitar tener relaciones sexuales. Sus razones para esperar afectarán lo que abstinencia significa para usted. Algunas personas se abstienen por una noche, otros se abstienen por un período más largo de tiempo. Usted puede tener sexo una vez y cambiar su forma de pensar la siguiente vez. La decisión es suya.

¿Cuáles son las ventajas de la abstinencia?

- Cualquier persona puede usarla en cualquier momento de su vida.
- Es gratuita y no tiene efectos médicos secundarios.
- Si es usada perfectamente, evita embarazos y enfermedades de transmisión sexual.
- Puede ser una elección poderosa.

¿Cuáles son las desventajas de la abstinencia?

- Sepa a lo que usted se refiere con “abstinencia”. Entienda sus límites y el por qué quiere esperar.
- Requiere planificación (con anticipación, separe un tiempo y lugar para hablar con su compañero(a) sobre sus creencias).
- Mantener la decisión de abstinencia puede ser difícil si usted recibe la presión de tener sexo. (es más fácil mantener una decisión si se piensa con anticipación y tener una idea de cómo lidiar con la presión).
- Alta tasa de ineficacia (aproximadamente 22%), si no es practicada correctamente en todo momento.

¿Dónde puedo aprender más?

Discuta su decisión con su compañero(a) y/o cualquier persona con la que tenga confianza y respeto. Algunas iglesias y otros programas de educación sexual tienen grupos de apoyo o clases para personas jóvenes quienes quieran esperar y no tener sexo hasta el matrimonio, o quienes quieran aprender y practicar las destrezas de rechazo.

¿Qué pasa si tengo sexo y no uso anticonceptivos?

Llame a la oficina para conseguir Pastillas Anticonceptivas de Emergencia para prevenir el embarazo hasta 5 días después de que haya tenido sexo sin protegerse. También se puede visitar www.Not-2-Late.com para más información.